Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11595	A. BUILDING _____ B. WING _____	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE MEMORY CARE	3059 EL CAMINO ROAD, LAS VEGAS, NEVADA ,89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an Initial State Licensure survey completed in your facility on 06/17/24, in accordance with Nevada Administrative Code, Chapter 449, Requirements for Residential Facilities for Groups. The facility has applied for licensure for ten Residential Facility for Group beds with an endorsement for Alzheimer's disease, Category II residents. The census at the time of the survey was two. Two resident records and three employee files were reviewed. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Name: JUAN CARLOS COMAHIG	Title: Owner	Date: 07/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11595	A. BUILDING _____ B. WING _____	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE MEMORY CARE	3059 EL CAMINO ROAD, LAS VEGAS, NEVADA ,89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0220 SS= F	Laundry & Linen Services Provided - NAC 449.213 Laundry and linen services. (NRS 449.0302) 1. A residential facility shall: (a) Provide laundry and linen services on the premises of the facility; or (b) Contract with a commercial laundry for the provision of those services. 2. A residential facility that provides its own laundry and linen services shall have accommodations which are adequate for the proper and sanitary washing and finishing of linen and other washable goods. 3. The laundry room in a residential facility must be situated in an area which is separate from an area where food is stored, prepared or served. The laundry must be adequate in size for the needs of the facility and maintained in a sanitary manner. The laundry room must contain at least one washer and at least one dryer. All the equipment must be kept in good repair. All dryers must be ventilated to outside the building. If a washer or dryer is located outside the residential facility, the washer or dryer must be in a room or enclosure. Inspector Comments: Based on observation and interview, the facility failed to ensure the dryer vents were maintained in a sanitary manner. Findings include: On 06/17/24 in the morning, the clothes dryer was vented to the exterior of the building. During a tour of the exterior's back patio, the vented opening from the dryer was observed to have an accumulation of lint. The Caregiver indicated it was unknown how long the vent had been filled and overflowing with lint. The facility did not have a policy and procedure in place that described a process for ensuring the dryer vents were checked and cleaned routinely at the interior and exterior of the building. On 06/17/24 in the afternoon, the Caregiver acknowledged the accumulation of lint and the lack of a cleaning process for the dryer vent during the exit interview. Severity: 2 Scope: 3	0220	A joint meeting of Governing Body was held on JUne 21,2024 to discuss the findings of the State initial Survey held on June 17, 2024. During the meeting , plan of correction were formulated, discussed and approved, including its implementation,by the operator. These plan of care were submitted to the Governing body, where then discussed, reviewed and approved by the Governing Body for implementation Included in the meeting were the review, discussion, approval and implementation of the plan of correction for strict compliance in the facility procedure in maintaining dryer vent in a sanitary manner. The administrator conducted a one-on- one inservice to the caregiver to instruct the caregiver to check on check on the interior and exterior dryer vent to ensure that there is no accumulation of lint. A daily log check was created and given to the caregiver as part of daily routine to ensure ensure compliance. Monthly log will be collected by the Administrator to monitor and tract compliance rate to ensure that the compliance were achieved	07/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11595	A. BUILDING _____ B. WING _____	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE MEMORY CARE	3059 EL CAMINO ROAD, LAS VEGAS, NEVADA ,89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0320 SS= F	Bedroom - Doors: Locks - NAC 449.220 Bedroom doors. (NRS 449.0302) 1. A bedroom door in a residential facility which is equipped with a lock must open with a single motion from the inside unless the lock provides security for the facility and can be operated without a key or any special knowledge. Inspector Comments: Based on observation and interview, the facility failed to ensure that bedroom doors in the facility were equipped with a lock that opened with a single motion from the inside. Findings include: On 06/17/24, all the bathroom and bedroom doors in the facility were equipped with double motion hardware. On 06/17/24 in the afternoon, the Caregiver acknowledged the bedroom doors were equipped with double motion hardware. The Caregiver was unaware of the requirement for resident doors to be installed with hardware equipped with single motion locks. Severity: 2 Scope: 3	0320	A joint meeting of Governing Body was held on June 21, 2024 to discuss the findings of the State initial Survey held on June 17, 2024. During the meeting , plan of correction were formulated, discussed and approved, including its implementation,by the operator. These plan of care were submitted to the Governing body, where then discussed, reviewed and approved by the Governing Body for implementation Included in the meeting were the review, discussion, approval and implementation of the plan of correction for strict compliance in the facility procedure in following to have all bedroom doors and bathroom be equipped with single motion from the inside The administrator discussed the implementation of having all bathroom doors and bedroom be equipped with single motion from the inside to the owner On June 26, 2024 , all doors were inspected and all bathroom and bedroom doors were changed to single motion from the inside.	07/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11595	A. BUILDING _____ B. WING _____	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE MEMORY CARE	3059 EL CAMINO ROAD, LAS VEGAS, NEVADA ,89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0358 SS= E	Bathrooms and Toilet Facilities - NAC 449.222 Bathrooms and toilet facilities; toilet articles. (NRS 449.0302) 8. All bathrooms and toilet facilities must be sufficiently lighted, and night-lights must be provided in hallways that lead from the bedrooms to the bathrooms and toilet facilities. Inspector Comments: Based on observation and interview, the facility failed to ensure residents had sufficient lighting to and from the bathrooms. Findings include: On 06/17/24, a tour of the facility revealed a lack of adequate lighting to and from the resident rooms to the three bathrooms. On 06/17/24 in the afternoon, the Caregiver acknowledged the lack of lighting to and from the bathrooms. Severity: 2 Scope: 2	0358	A joint meeting of Governing Body was held on June 21, 2024 to discuss the findings of the State initial Survey held on June 17, 2024. During the meeting , plan of correction were formulated, discussed and approved, including its implementation,by the operator. These plan of care were submitted to the Governing body, where then discussed, reviewed and approved by the Governing Body for implementation Included in the meeting were the review, discussion, approval and implementation of the plan of correction for strict compliance in the facility procedure in ensuring that the facility bathroom and toilet will sufficiently lighted and hallways must have a nightlight that lead from the bedroom to the bathroom and toilet. The administrator discussed the implementation of having all bathroom and toilet be sufficiently lighted and hallways must have a nightlight that lead from the bedroom to the bathroom and toilet by June 26,2024. On June 26,2024, all bathroom and toilet have sufficient lighting and hallways have nightlight in placed that lead from the bedroom to the bathroom and toilet.	07/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11595	A. BUILDING _____ B. WING _____	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE MEMORY CARE	3059 EL CAMINO ROAD, LAS VEGAS, NEVADA ,89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0410 SS= F	Accommodations for Residents - NAC 449.227 Accommodations for residents with restricted mobility. (NRS 449.0302) A residential facility with a resident who uses a wheelchair or a walker shall: 1. Have hallways, doorways and exits wide enough to accommodate a wheelchair or walker; 2. Have ramps to accommodate access to areas used by residents; and 3. Provide assistance to such a resident at all steps located inside the facility on the first floor that is entirely above grade Inspector Comments: Based on observation and interview, the facility failed to install ramps to accommodate access to areas used by residents with restricted mobility. Findings include: On 06/17/24 in the morning, the facility had three steps that led to the front door entrance. The facility did not provide the required ramps to assist residents who may have limited mobility and required assistance with walking, or ambulating to and from the building's front door. On 06/17/24 in the afternoon, the Caregiver acknowledged there was no ramp per the requirement, and installation of a ramp would provide assistance to future residents who have mobility challenges. Severity: 2 Scope: 3	0410	A joint meeting of Governing Body was held on June 21, 2024 to discuss the findings of the State initial Survey held on June 17, 2024. During the meeting , plan of correction were formulated, discussed and approved, including its implementation,by the operator. These plan of care were submitted to the Governing body, where then discussed, reviewed and approved by the Governing Body for implementation Included in the meeting were the review, discussion, approval and implementation of the plan of correction for strict compliance in the facility procedure in providing ramp to assist residents who have limited mobility and required assistance with walking , or ambulating to and from the building's from door The administrator discussed to order ramp to the owner in order to accommodate residents with limited mobility and to assist residents who have limited mobility and required assistance with walking , or ambulating to and from the building's from door The facility received the ordered ramp on July 1, 2024 and is now available to be used for residents who with limited mobility and required assistance with walking, ambulating to and from the building's front door	07/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11595	A. BUILDING _____ B. WING _____	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE MEMORY CARE	3059 EL CAMINO ROAD, LAS VEGAS, NEVADA ,89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure all oxygen tanks kept in the facility were secured in a stand or to the wall. Findings include: On 06/17/24, in the closet of resident room number 5, was an unsecured E-Size Oxygen tank not in an appropriate cart or stand. The Caregiver was present when the oxygen tank was discovered and acknowledged the oxygen tank was unsecured. Severity: 2 Scope: 1	0690	A joint meeting of Governing Body was held on June 21, 2024 to discuss the findings of the State initial Survey held on June 17, 2024. During the meeting , plan of correction were formulated, discussed and approved, including its implementation,by the operator. These plan of care were submitted to the Governing body, where then discussed, reviewed and approved by the Governing Body for implementation Included in the meeting were the review, discussion, approval and implementation of the plan of correction for strict compliance in the facility procedure on how to safely secure or keep oxygen tank in the facility The owner ordered a rack to secure the oxygen tank the day after the survey. The facility received the ordered a secured rack for the oxygen tank the same day when it was ordered. The administrator checked the oxygen rack during the meeting and provide instructions to the owner and caregiver to ensure that all residents with oxygen tanks must be secured in rack for safety.	07/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11595	A. BUILDING _____ B. WING _____	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE MEMORY CARE	3059 EL CAMINO ROAD, LAS VEGAS, NEVADA ,89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure an exit door had an audible alarm that sounded upon opening. Findings include: On 06/17/24 in the morning, the following exits were missing alarms: -the facility patio door leading to the backyard; and -an office exit door leading to the exterior side yard. On 06/17/24 in the afternoon, the Caregiver acknowledged the two doors and was unaware an alarm should have been activated and audible at those exit door locations. Severity: 2 Scope: 3	0991	A joint meeting of Governing Body was held on June 21, 2024 to discuss the findings of the State initial Survey held on June 17, 2024. During the meeting , plan of correction were formulated, discussed and approved, including its implementation,by the operator. These plan of care were submitted to the Governing body, where then discussed, reviewed and approved by the Governing Body for implementation Included in the meeting were the review, discussion, approval and implementation of the plan of correction for strict compliance in the facility procedure in in ensuring that the alarm on facility patio door leading to the backyard and the office exit door leading to the exterior side yard are operational and will have an audible when it opens The administrator discussed to ensure that the alarm on the patio door leading to the backyard and the office exit door leading to the exterior side yard are functional and will create audible alarm every time it opens Administrator provided instruction on proper checking of alarms on exit doors and added to the daily log check of the caregiver to ensure that all exit door will have an audible sound when it opens Monthly log will be collected by the Administrator to monitor and tract compliance rate to ensure that the compliance were achieved	07/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11595	A. BUILDING _____ B. WING _____	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE MEMORY CARE	3059 EL CAMINO ROAD, LAS VEGAS, NEVADA ,89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to residents. Findings include: On 06/17/24 in the morning, a built-in desk with over-head cabinet storage and drawers located beneath a desktop were inspected. Found unsecured in the unlocked cabinet space were air fresheners and a container of septic tank chemicals. In the unlocked drawer were a pair of scissors and hot glue adhesive. On 06/17/24 in the afternoon, the Caregiver acknowledged there were toxic substances and the pair of scissors unsecured in the built-in desk storage areas during the exit interview. Severity: 2 Scope: 3	0999	A joint meeting of Governing Body was held on June 21, 2024 to discuss the findings of the State initial Survey held on June 17, 2024. During the meeting , plan of correction were formulated, discussed and approved, including its implementation,by the operator. These plan of care were submitted to the Governing body, where then discussed, reviewed and approved by the Governing Body for implementation Included in the meeting were the review, discussion, approval and implementation of the plan of correction for strict compliance in the facility procedure in following safety to ensure all toxic substances and sharp objects were inaccessible to residents Administrator provided instructions to the caregiver and owners that all toxic substance and sharp objects must be kept locked. During the meeting, the caregiver informed the administrator that all toxic and sharp materials were all kept in a secured area and inaccessible to residents right after the exit interview for safety The administrator discussed the implementation of a daily check on all sharps and toxic material in the facility to ensure that it is kept in a locked place and inaccessible to residents The administrator will collect monthly log to ensure that the facility is safe and meeting the compliance	07/29/2024