DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/21/2025**

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 annual state licensure survey and a complaint investigation completed in your facility on 05/21/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's Disease, three Category II and Seven Category II residents (Alzheimer's). The census at the time of the survey was Eight. Eight resident files and four employee files were reviewed. The facility received a grade of A. There was one complaint investigated: Unsubstantiated: 1. Complaint #NV00073507 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaint included: Observations of grooming and physical appearance for residents, food supply for residents, staff to resident interactions, resident care, and a tour of the facility. Interviews were conducted with the Administrator, Caregivers, and residents. Document review included menus and Ownership documents. 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 investigation, 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: JUAN CARLOS COMAHIG | Title: Provider | Date: 07/07/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/21/2025**

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 resident bedroom doors and resident bathroom doors were equipped with a single motion lock. Findings include: On 05/21/25 in the morning, resident bedroom doors and resident bathroom doors had double motion locks requiring residents to turn a button on the door knob to lock and unlock the door from the inside. On 05/21/25 in the morning, a Caregiver acknowledged the resident bedroom doors and resident bathroom doors had double motion locks. On 05/21/25 in the afternoon, the Administrator acknowledged the resident bedroom doors and resident bathroom doors required single motion locks. Severity: 2 Scope: 3 This is a repeat deficiency from initial survey dated 06/17/24.	0320	On 6/3/ 2025 , all resident bedroom and bathroom doors with double motion locks have been identified and removed . These locks were immediately replaced with approved single motion locking mechanism. These corrective action ensures resident can safely and independently lock/unlock their doors with one motion from the inside. A full facility wide audit of all interior door locks was conducted on 5/25/2025 by the administrator and maintenance personnel. Staff have been trained on recognizing acceptable hardware standards , including requirements for single motion locks applicable to residential care facilities. The administrator or designee will inspect all bedroom and bathroom door hardware monthly and any deficiencies will be corrected within 48 hours .	06/03/2025
0515 SS= F	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on record review and interview, the facility failed to develop a person-centered service plan for	0515	As of 6/3/2025, person centered service plan have been developed and placed in the charts of all 8 affected residents (R1-R8) . Each Plan was completed in coordination with the residents, reponsible party, caregivers and supervising RN. The plan reflects the individual needs, goal , preferences , diagnosis including risk factors. In service training on staff regarding PCSP provided on that same day. A new resident admission checklist was updated to include completion of PCSP within 14 days or prior to direct care service initiation. The RN /designee is now responsible for ensuring timely development and updates of PCSP in coordination with the caregivers and family/ responsible parties.	06/03/2025

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/21/2025**

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
	8 of 8 residents (Resident #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: Resident #1 (R1) R1 was admitted on 12/01/24, with diagnoses including chronic pulmonary obstructive disease and diabetes. R1's file lacked a person-centered service plan. Resident #2 (R2) R2 was admitted on 09/01/24, with diagnoses including dementia and hypertension. R2's file lacked a person-centered service plan. Resident #3 (R3) R3 was admitted on 04/06/24, with diagnoses including dementia and anxiety. R3's file lacked a person-centered service plan. Resident #4 (R4) R4 was admitted on 10/08/24, with diagnoses including encephalopathy and diabetes. R4's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted on 04/09/25, with diagnoses including dementia and hypertension. R5's file lacked a person-centered service plan. Resident #6 (R6) R6 was admitted on 09/07/24, with diagnosis including senile degeneration of the brain. R6's file lacked a person-centered service plan. Resident #7 (R7) R7 was admitted on 10/08/24, with diagnoses including dementia and anemia. R7's file lacked a person-centered service plan. Resident #8 (R8) R8 was admitted on 02/28/25, with diagnoses including cardiovascular accident and leukopenia. R8's file lacked a person-centered service plan. On 05/21/25 in the afternoon, the Administrator confirmed person-centered service plans were not developed for the residents. Severity: 2 Scope: 3		Quarterly reviews of each PSCP will be conducted and documented with updates made as needed based on condition changes or family input. The administrator will conduct monthly audit of residents chart to verify that all PCSP are complete , current, and signed by relevant parties.	
1600 SS= F	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104) 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent	1600	As of 6/3/ 2025 , the resident records for all 8 identified individuals (R1-R8) have been reviewed and updated to include Preferred pronoun, gender identity/ expression, sexual orientation (if voluntary disclosed) . These information was obtained from the residents and their authorized representative and documented in both the admission file and person centered service plan. Residents unable to self report due to cognitive impaired were documented and family were consulted.	06/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/21/2025**

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
	practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on interview and record review, the facility failed to ensure 8 of 8 residents files included documentation of preferred pronoun, gender expression and sexual orientation (Resident #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: Resident #1 (R1) R1 was admitted on 12/01/24, with diagnoses including chronic pulmonary obstructive disease and diabetes. R1's file lacked documentation of preferred pronoun,		To prevent from recurrence, a new resident identity and inclusion form was developed to gather information on pronoun preference , gender identity, and sexual orientation at the time of admission or initial assessment. Admission and service plan were revised / created to include mandatory fields for identity - related information with option such as " declines to state", " Unknown ", " unable to assess". All forms were revised to include affirmation of residents rights to self- identity, in compliance with the regulation. Staff were also retrained on culturally competent care, privacy, dignity, and inclusion , empahsizing respectful language and proper documentation. To monitor compliance, the administrator or designee will audit 100 % of new admission for identity documentation within 7 days of move in and a quarterly chart audit will be conducted to ensure documentation is complete and up to date .	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/21/2025**

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
	gender expression and sexual orientation. Resident #2 (R2) R2 was admitted on 09/01/24, with diagnoses including dementia and hypertension. R2's file lacked documentation of preferred pronoun, gender expression and sexual orientation. Resident #3 (R3) R3 was admitted on 04/06/24, with diagnoses including dementia and anxiety. R3's file lacked documentation of preferred pronoun, gender expression and sexual orientation. Resident #4 (R4) R4 was admitted on 10/08/24, with diagnoses including encephalopathy and diabetes. R4's file lacked documentation of preferred pronoun, gender expression and sexual orientation. Resident #5 (R5) R5 was admitted on 04/09/25, with diagnoses including dementia and hypertension. R5's file lacked documentation of preferred pronoun, gender expression and sexual orientation. Resident #6 (R6) R6 was admitted on 09/07/24, with diagnosis including senile degeneration of the brain. R6's file lacked documentation of preferred pronoun, gender expression and sexual orientation. Resident #7 (R7) R7 was admitted on 10/08/24, with diagnoses including dementia and anemia. R7's file lacked documentation of preferred pronoun, gender expression and sexual orientation. Resident #8 (R8) R8 was admitted on 02/28/25, with diagnoses including cardiovascular accident and leukopenia. R8's file lacked documentation of preferred pronoun, gender expression and sexual orientation. On 05/21/25 in the afternoon, the Administrator confirmed there was no documentation of preferred pronoun, gender expression and sexual orientation for Resident #1, #2, #3, #4, #5, #6, #7, and #8. Severity: 2 Scope: 3			