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 _____	**09/22/2025**

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 a complaint investigation completed in your facility on 09/22/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was ten. The sample size was five. The facility received a grade of A. There was one complaint investigated. Unsubstantiated: 1. Complaint #NV00074566 was substantiated. (See Tag Y0557) The investigation of the complaint included: Observation of grooming and physical appearance for residents, bed rails, portable oxygen containers, and a tour of the facility. Interviews were conducted with residents and caregivers. Clinical Record Review of five records, which included the resident of concern. No documents 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 deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: COMAHIG, GERLIE Title: Provider Representative Date: 10/16/2025

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.

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0557 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation, interview and record review, the facility failed to ensure residents were free from restraints, for 1 of 10 residents (Resident #3). Findings include: Resident #3 (R3) R3 was admitted on 10/08/24 with dementia and Alzheimer's. On 09/22/25 in the morning, R3 was observed sitting in a Geri-chair with a lap tray attached, at the dining room table. R3 was unable to release the lap tray on the Geri-chair resulting in R3 being restrained. The lap tray covered R3's lower extremities for two hours during the survey and R3 was unable remove R3's self from the Geri-chair. On 09/22/25 in the morning, R3 was unable to verbalize answers to questions, due to cognitive deficits. On 09/22/25 in the morning, E1 verbalized R3 was unable to release the lap tray without staff assistance and this was preventing R3 from getting out of the chair. Severity: 2 Scope: 1	0557	The lap tray was immediately removed from Resident #3's Geri-chair on **09/22/25**. The resident was assessed by thenurse to ensure no physical harm, skin injury, or emotional distress occurreddue to the restraint. The resident's physician and responsible party werenotified of the incident and intervention. A care plan update was completed to reflect the resident's current seating and safety needs without use of anyrestrictive device. The **Restraint-Free Policy** was reviewed and revised to clearly define the difference between positioning devices and restraints, emphasizing that trays must be easily self-releasableor documented as a restraint with appropriate justification and physicianorder. A **Staff In-Service Training** was conducted on **09/24/25** covering: Definition and types of restraints, Resident rights and restraint-free environment, Safe use of adaptive equipment and self-releasecriteria including documentation order requirements for any approved restraint use. The Administrator / Designee will perform weekly audit for 30 days of all residents using Geri-chairs, wheelchair or positioning device to ensure compliance . After that, audit will continue monthly then quarterly . Reports will be discussed during QA/PI meeting for ongoing monitoring and corrective actions as needed.	10/07/2025