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 _____	**11/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE GOLDEN CARE HOME	**3858 MOONGATE CIR, LAS VEGAS, NEVADA ,89103**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed at your facility on 11/19/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was seven. Ten resident files and eight employee files were reviewed. The facility received a grade of A. The sample size was ten. There were seven complaints investigated. Substantiated: 1. #NV00074796 was substantiated. (See Tag 860) 2. #12249 was substantiated. (See TAG 557) Substantiated without deficient practice: 3. #12400 was substantiated with no deficient practice 4. #NV00074701 was substantiated with no deficient practice. 5. #12539 was substantiated with no deficient practice. Unsubstantiated: 3. #12250 could not be substantiated. No regulatory deficiencies could be identified. 7. #NV00074799 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaints included: Observation of resident care, caregiver-resident interactions, call bell placement, medication administration, call bell response time, the facility menu, securing of residents' medication, and a tour of the facility. Interviews were conducted with the Residents of Concern, Residents, Caregivers, Administrator, the Owner, and a hospice nurse. Clinical Record Review of ten records, which included the Residents of Concern. Document review included admission agreements, facility menus, employee files, and facility policy and procedures. The findings and conclusions of any investigation by the Division of Purchasing and Compliance 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	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: DONN LIGASON Title: Owner Date: 02/26/2026

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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	were identified:			

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0050 SS= D	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on interview and record review, the facility failed to ensure Caregivers did not provide services outside their scope of practice. (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 10/15/25 with diagnoses including fracture of the third lumbar vertebrae and chronic kidney disease. R1's record documented R1 was evaluated on 10/07/25 for an open lesion on R1's rear scalp. The wound was documented as being 4 months old with an area of 6.88 centimeters (cm), a length of 3.71 cm and a width of 2.8 cm. Treatment was to include a normal saline cleansing solution with composite dressing and no secondary dressing. The goal of care was to monitor and manage the wound. On 11/19/25 in the morning, R1 was observed with a large bandage on their head. R1 reported the wound on their head was cancer and verbalized being unaware of who took care of the wound. On 11/19/25 in the afternoon, Employee #1 (E1) verbalized hospice visited once a month to care for R1's wound. According to E1, Caregivers apply alcohol and triple antibiotic ointment to the wound and change R1's wound bandage approximately every other day. On 11/21/25 in the afternoon, a Hospice Nurse reported the instructions to the facility were to contact hospice regarding any needed wound care for R1. According to the Hospice Nurse, on 2 or 3 occasions there were bandages on R1's wound not applied by the Hospice Nurse. Severity: 2 Scope: 1	0050	TAG 0050 – Administrator Responsibilities NAC 449.194 Corrective Action: The Administrator immediately contacted hospice to clarify wound care orders for R#1 and confirm nurse visit frequency. Wound care is performed only by hospice nursing staff. Caregivers were instructed to stop performing any wound care outside their scope of practice. Documentation was placed in the resident record. Staff received wound care education and scope of practice review. Monitoring: The Administrator and Owner will review hospice documentation weekly for 30 days. Completion Date: 11/19/25 Responsible Party: Administrator and Owner	11/19/2025

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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 interview and record review, the facility failed to ensure bed rails were not used as a restraint for 1 of 10 sampled residents (Resident #9). Findings include: Resident #9 (R9) R9 was admitted on 07/29/25 with diagnosis of including Chronic Obstructive Pulmonary Disease (COPD), Orthopedic amputation, Muscle Wasting and Atrophy and passed away on 09/06/25. On 11/19/25 in the afternoon, E1 and E2 explained that when hospice had set up R9's bed the half side bed rail was positioned in the upright position. The staff indicated they assumed the bed rail was ordered to be in the upright position by the hospice physician so the bedrail was always left in the upright position. The facility staff indicated R9 would require assistance with lowering the bedrail and was not able to reposition themself by using the bedrail. On 11/19/25 in the afternoon, R9 was transferred from a skilled nursing facility (SNF) and hospice care had been established prior to admission. The facility care plan dated 07/29/25 had a section subtitled, side rails, at night only and constantly. The facility had marked off side rails and wrote 1/2 to the side. On 11/19/25 in the afternoon, the facility staff all verbalized R9 was unable to manipulate the bed rails independently without assistance from staff. Severity: 2 Scope: 1 Complaint #12249	0557	TAG 0557 – Restraints / Bed Rails NAC 449.262 Corrective Action: Bed rail use for R#9 was discontinued immediately. The Restraint and Bed Rail Policy was reviewed with staff. Education was provided regarding proper use and resident rights. Monitoring: The Administrator and Owner will conduct weekly room checks for 30 days. Completion Date: 11/19/25 Responsible Party: Administrator and Owner	11/19/2025
0820 SS= D	Tracheostomy or Open Wound - NAC 449.2734 Residents having tracheostomy or open wound requiring treatment by medical	0820	TAG 0820 – Open Wound / Medical Exemption	11/27/2025

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	professional; residents having pressure or stasis ulcers. (NRS 449.0302) 1. A person who has a tracheostomy or an open wound that requires treatment by a medical professional must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The wound is in the process of healing or the tracheostomy is stable or can be cared for by the resident without assistance; (b) The care is provided by or under the supervision of a medical professional who has been trained to provide that care; or (c) The wound is the result of surgical intervention and care is provided as directed by the surgeon. Inspector Comments: Based on record review and interview, the facility failed to ensure a medical exemption was received and approved prior to admitting a resident with wounds (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 10/15/25 with diagnoses including fracture of the third lumbar vertebrae and chronic kidney disease. R1's record documented R1 was evaluated on 10/07/25 for an open lesion on R1's rear scalp. The wound was documented as being 4 months old with an area of 6.88 centimeters (cm), a length of 3.71 cm and a width of 2.8 cm. Treatment was to include a normal saline cleansing solution with composite dressing and no secondary dressing. The goal of care was to monitor and manage the wound. On 11/19/25 in the morning, R1 was observed with a large bandage on their head. R1 reported the wound on their head was cancer and verbalized being unaware of who took care of the wound. On 11/19/25 in the afternoon, Employee #1 (E1) verbalized hospice visits once a month to care for R1's wound. According to E1, Caregivers apply alcohol and triple antibiotic ointment to the wound and change R1's wound bandage approximately every other day. There was no documented evidence the facility applied		NAC 449.2734 Corrective Action: The resident identified during survey was admitted with a pre-existing cancer-related wound. A medical exemption review was not completed at the time of admission. The resident passed away on 11/26/25 and is no longer in the facility. The facility reviewed and updated its admission process to ensure medical exemption determination is completed prior to admission when required. All current residents were reviewed and no residents at this time require a medical exemption. The admission checklist was updated to include review for open wounds and exemption requirements. Monitoring: The Administrator and Owner will review all new admissions prior to move-in and monitor for any change in condition requiring exemption for 30 days. Completion Date: 11/27/25 Responsible Party: Administrator and Owner	

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	to the Bureau for a medical exemption for R1's wound. On 11/19/25 in the afternoon, E1 confirmed the facility had not submitted for approval to the Bureau a medical exemption waiver for R1's wound. Severity: 2 Scope: 1			
0860 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he or she requires. (b) Monitor the ability of the resident to care for his or her own health conditions and document in writing any significant change in his or her ability to care for those conditions. Inspector Comments: Based on observation and interview, the facility failed to ensure 2 of the 7 residents living in the facility at the time of the survey were acknowledged and assisted out of bed (Residents #1 and #10). Findings include: On 11/19/25 in the morning, one resident was in the living room, one resident was ambulating in the house independently, and the other residents were still in bed. Resident #1 (R1) R1 was admitted on 10/15/25 with diagnoses including fracture of the third lumbar vertebrae and chronic kidney disease. On 11/19/25 at 10:15 AM, R1 was observed lying in bed with the half-rails up. R1 reported that they didn't have anyone to assit them out of bed, and the walker was in the closet. R1 verbalized that it had been quite a while since the caregivers had assisted them out of bed. Resident #10 (R10) R10 was admitted on 04/16/24 with diagnoses including cardiovascular accident and mass of brain. On 11/19/25 in the morning, R10 was lying in bed with the head of the bed raised, coughing and yelling loudly and incoherently. R10 reported the caregivers got them out of bed one time a week. On 11/19/25 at 12:15 PM,	0860	TAG 0860 – Medical Care / Personal Assistance NAC 449.274 Corrective Action: Residents #1 and #10 were assessed for mobility and assistance needs. Care plans were updated accordingly. All residents were assessed for mobility assistance needs. Staff were re-educated on assisting residents and documentation requirements. Personal Care Policy was reviewed with staff. Monitoring: Daily mobility documentation was implemented. The Administrator and Owner will review documentation weekly for 30 days. Completion Date: 11/19/25 Responsible Party: Administrator and Owner	11/19/2025

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	Employee #1 (E1) indicated that some residents wanted to get out of bed, but the caregivers would tell them no, they could not get out of bed and to stay in their bed. E1 explained that the residents were agitated and wanted to go home, but they could not walk. Severity: 2 Scope: 1 Complaint # NVS00074796			
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC	0878	TAG 0878 – Medication Administration NAC 449.2742 Corrective Action: Medication orders for Resident #3 were clarified with the physician/hospice. Incorrect labeling was removed. The MAR was updated to reflect the current physician order. Medication reconciliation was completed. A full medication audit was completed for all residents to ensure physician orders, labels, and MARs match. Medication administration policy was reviewed with staff. Staff were re-trained on PRN documentation, medication changes, and timely physician order updates. Monitoring: Weekly medication audits will be conducted by the Administrator and Owner for 30 days. Completion Date: 11/19/25 Responsible Party: Administrator and Owner	11/19/2025

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	449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure medications was administered appropriately by staff for 1 of 10 residents (Resident #3). Findings include: Resident #3 (R3) R3 was admitted on 08/30/25 with diagnoses including early onset Alzheimer's Disease, Hypertension, Transient Ischemic Attack (TIA), Cerebral Infarction, left facial droop, disorientation, failure to thrive and dementia. On 11/19/25 in the morning, R3's medication container was observed. A medication bottle had a label which read Acetaminophen 650 mg, take one tablet by mouth every 6 hours as needed for pain/fever. The medication bottle lid was marked 2 tabs in the AM; 2 tabs in the PM. The lid lacked documented evidence of whether the medication was to be administered as scheduled or as needed. Another medication bottle in R3's over flow bag had a label which read Acetaminophen 325 mg, take two tablets by mouth every 6 hours as needed for pain/fever. The Hospice care plan included a current medication list which documented the following on 08/30/25, Acetaminophen 650 mg, quantity 10, take one tablet by mouth every 6 hours as needed for pain/fever which matched the label on the			

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	Acetaminophen bottle in R3's medication bin but did not match the administration instructions on the bottle's lid. An Ultimate User Agreement dated 08/30/25, documented R3 required medication administration. The Medication Administration Record (MAR) titled PRN Medications dated September 2025, October 2025 and November 2025, documented Acetaminophen 325 mg, take two tablets by mouth every 6 hours as needed for pain/fever which matched the label on the bottle of Acetaminophen located in R3's over flow bag. On 11/19/25 in the afternoon, Employee #1 (E1) indicated if R3 requested or needed the PRN Acetaminophen, E1 would administer the PRN medication by following the label directions on the bottle which was administering one 650 mg tablet in one administration. On 11/19/25 in the afternoon, E2 indicated they would have administered the medication by following the markings on the medication lid which was administering two 650 mg tablets in one administration. On 11/19/25 in the afternoon, E1 and E2 confirmed they were not administering Acetaminophen the same way which was causing R3 to get different doses in one administration. On 11/19/25 in the afternoon, the Owner acknowledged the findings plus the possibility of administering the medication incorrectly. The Owner explained there was a change in the order but was unable to present the physician's change order prior to the end of survey. The Owner used the already marked lid from the old bottle, which read, 2 tabs AM; 2 tabs PM. The Owner acknowledged the lid was meant for the original lower dosage of Acetaminophen (325 mg). Severity: 2 Scope: 1			