

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 A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2024	
NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY GROUP CARE 2				STREET ADDRESS, CITY, STATE, ZIP CODE 1140 MANHATTAN STREET, RENO, NEVADA ,89512			
(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 conducted at your facility on 05/30/2024, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was nine. Nine resident records were reviewed, and three employee records were reviewed. The facility received a grade of A. There was one complaint investigated. Complaint #NV00070165 with the following allegations could not be substantiated due to a lack of evidence. Allegation #1: Two residents did not have Activities of Daily Living (ADLs) performed. Allegation #2: Two residents were not administered medications on 12/30/2023, 12/31/2023, 01/01/2024 and 01/02/2024. The investigation into the allegation included: Interviews were conducted with the Administrator and three residents. Reviewed nine resident records including both residents of concern. Reviewed three employee records to include medication management training and resident rights. 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. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report for your records.	0000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name:
REPRESENTATIVE'S SIGNATURE

Title:

Date:

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.