STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205	A. BUILDING _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY GROUP CARE	2690 MARGARET DRIVE, RENO, NEVADA ,89506

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RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual and complaint investigation survey completed at your facility on 10/15/2025. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category II residents. The census at the time of the survey was seven. Five resident records, three closed resident records, and three employee records were reviewed. The facility received a grade of A. The sample size was eight. There were three complaints investigated. Substantiated: 1. Complaint #NV00074291 was substantiated (See Tag Y0920). Unsubstantiated: 2. Complaint #NV00073932 could not be substantiated. No regulatory deficiencies could be identified. 3. Complaint #NV00074630 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the Complaints included:			

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	Observations of residents, resident rooms, resident bathrooms, kitchen, a meal preparation, facility floors, temperatures throughout the facility, and indoor and outdoor environments. Interviews were conducted with residents, a Caregiver and the Owner/Caregiver. Reviewed eight sampled resident records including the resident of concern, resident medications, and three employee records.			
Y 0920 SS= F	**NAC 449.2748** **Medication Storage.** 1. Medication including, without limitation, any over-the-counter medication stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator including, without limitation, any over-the-counter medication must be kept in a locked box unless the refrigerator is locked or is located in a locked room. 3. Medication including, without	Y 0920	1. The facility is aware that all medication must be in a locked unit 2. A poster stating such will be posted on the medication cabinet 3. Moving forward this administrator will be double checking cabinets during walk throughs 4. Administrator 5. 11/26/25	11/26/2025

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	limitation, any over-the-counter-medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation and interview, the facility failed to ensure resident medications were secured. Findings include: On 10/15/2025 at 10:19 AM, a cabinet under the kitchen counter was unlocked and contained resident medications. On 10/15/205 at 10:20 AM, the Owner/Caregiver confirmed the cabinet under the kitchen counter contained resident medications, and the door did not have a lock on it. The Owner/Caregiver confirmed the medications should have been secured and placed in the cabinet with the lock. Severity: 2 Scope: 3 Complaint #NV00074291			
Y 1810 SS= F	**NAC 449.0109** **Program and policy for control of infection; designation and training of person responsible for infection control. (NRS439.200, 449.0302)**	Y 1810	1. Facility could not locate new ic plan that was submitted at the annual survey POC; 2. A new IC plan was created which includes: the facility plan, and the IC Preventionist annual certs 3. New Administrator will do an annual review or as information changes; the cover page will be updated with new date as updates happen	11/26/2025

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	1. A facility for the dependent shall: (a) Develop and carry out an infection control program to prevent and control infections within the facility; (b) Review the infection control program, including, without limitation, the infection control policy adopted pursuant to subsection 2, at least annually to ensure that the program meets current evidence-based standards for infection control plans and the safety needs of residents, staff and visitors; and (c) Develop and carry out a comprehensive plan for emergency preparedness. 2. To carry out the infection control program developed pursuant to paragraph (a) of subsection 1, the facility shall adopt an infection control policy. The policy must include, without limitation, current infection control guidelines developed by a nationally recognized infection control organization that are appropriate for the scope of service of the facility. Such nationally recognized organizations include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations. 6. The plan for emergency preparedness developed pursuant to paragraph (c) of subsection 1 must address internal and external emergencies and local and widespread emergencies. Such emergencies must include, without limitation, emerging infectious diseases. Inspector Comments: Based on interview, the facility failed to develop a complete infection control program and corresponding policies to		4. Administrator/Owner 5. 11/26/2025	

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	prevent and control infections within the facility. Findings include: On 10/15/2025 at 10:44 AM, the Owner/Caregiver confirmed the facility lacked a completed infection control program and policies related to influenza, pneumonia, respiratory syncytial virus (RSV), and other potentially infectious diseases. The Owner/Caregiver verbalized having believed the previous administrator had developed the policies. Severity: 2 Scope: 3 This is a Repeat Deficiency from the annual survey on 03/27/2025.			
Y 1600 SS= C	**NAC 449.011943 and R004-24** **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 practicable and	Y 1600	1 It was identified that the facility could not located the new gender expression policy that was previously submitted for the annual survey SOD; 2. The new administrator created an updated policy; which is included in the facility P&P book as well as posted on the posting board 3. The gender policy will be implemented moving forward 4. Administrator 5. 11/26/25	11/26/2025

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	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 subsection1, include, without limitation: (a) The preferred name and pronoun ofthe patient or resident; (b) The gender identity or expressionof 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			

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	(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, the facility failed to develop policies to ensure residents were addressed by their preferred name and pronoun in accordance with their gender identity or expression, and sexual orientation. Findings include: On 10/15/2025 at 10:54 AM, the Owner/Caregiver confirmed the facility did			

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	not have policies developed related to resident gender expression. The Owner/Caregiver verbalized having believed the previous administrator had developed the policies. Severity: 1 Scope: 3 This is a Repeat Deficiency from the annual survey on 03/27/2025.			