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 _____	**04/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN MEADOWS RESIDENTIAL	**4119 MEADOWGLEN CIRCLE, LAS VEGAS, NEVADA ,89121**

(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 initiated on your facility on 04/05/17 and completed on 04/07/17. This complaint investigation was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The census at the time of the survey was 10. The sample size was 5. There was one complaint investigated. Complaint #NV00048707 with two allegations could not be substantiated. The following allegations could not be substantiated: Allegation #1 - The facility restrained a resident. Allegation #2 - The facility failed to provide the appropriate level of care to a resident. The investigation into the allegations included: A tour of the facility, including observation of all residents and environment. Interviews were conducted with two caregivers and two residents, including resident of concern. Review of five resident files/medical records including the resident of concern. Review of the facility admission policy. 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. There were no regulatory deficiencies identified at this time. Please retain a copy for your records.	0000		

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