

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER GOLDEN VILLA CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 DUNEVILLE ST, LAS VEGAS, NEVADA ,89146	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual and complaint State Licensure survey initiated at your facility on 10/03/23 and completed on 10/19/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or persons with chronic illness, Category II residents. The census at the time of the survey was nine. Nine resident files and three employee files were reviewed. The facility received a grade of A. There were two complaints investigated. Verified without deficient Practice: 1. Complaint #NV00069488 was verified without deficient practice. Unverified: 2. Complaint #NV00069589 was unverified. The investigation of Complaints included: Observation of grooming and physical appearance for residents, lunch service, shower facilities, staff/resident interactions, and a tour of the facility. Interviews were conducted with residents and caregivers. Clinical Record Review of nine records, which included the residents of concern. Document Review included facility policy and procedures and pest control receipts. 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 necessary. Please retain a copy for your records.			

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.