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 _____	**11/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VILLA CARE HOME	**1505 DUNEVILLE ST, LAS VEGAS, NEVADA ,89146**

(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 completed at your facility on 11/20/23, 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 seven. Sample size was 5 residents. The facility received a grade of A. There was one complaint investigated. Verified: 1. Complaint #NV00069787 was verified. (See TAG Y0840) The investigation into the complaint included: Observation of physical appearance of residents, exterior and surrounding area of the facility and employee interactions with residents. Interviews were conducted with the House Manager, a Caregiver and resident of concern. Record review of five records, including the resident of concern. Document review, including facility policies, procedures and incident reports. 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. The following regulatory deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JOANNE MISURACA Title: Administrator Date: 01/26/2024

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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0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on document review and interview, the facility failed to maintain an accurate staffing schedule, including staffing changes. Findings include: On 11/20/23 in the morning, review of the October 2023 Staffing Schedule revealed two staff working daily for the entire month. There were no work hours or shifts on the schedule to reflect which staff was working when, and no amendments to the schedule for any shift changes. Employee #1 (E1) and Employee #2 (E2) were documented on the Staffing Schedule as working on 10/19/23. A Facility Incident Report dated 10/19/23 at 6:13 PM, documented E2 was off duty on 10/19/23. On 11/20/23 in the afternoon, E2 confirmed being on the schedule for 10/19/23, but E2 did not work that day. E2 confirmed Employee #3 (E3) was on duty on 10/19/23, but was not on the Staffing Schedule. On 11/20/23 in the afternoon, E2 confirmed the schedule was incomplete regarding work shift times, and had not been changed regarding E2 not being on duty on 10/19/23, and E3 who worked in October 2023, being added to the schedule. Severity: 1 Scope: 3	0088	Tag 0088 1. The facility failed to maintain a correct monthly schedule. A monthly written staff schedule will now be kept which includes the number and type of staff of the facility assigned for each shift. The schedule will be amended if any changes are made. (See attached) 2. The administrator reviewed with staff regarding the monthly schedule. Schedules will be kept for 6 months. The schedule will be amended if any changes are made. 3. The administrator will monitor the monthly schedule at visits to ensure the deficient practice does not recur. 4. The administrator will be responsible for ensuring the plan of correction is implemented. 5. Date of Compliance: 1/11/2024	01/11/2024

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0100 SS= D	Personnel File - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his or her employment at the residential facility; (c) Records relating to the training received by the employee; (e) Evidence that the references supplied by the employee were checked by the residential facility. Inspector Comments: Based on record review and interview, the facility failed to ensure an employee file was maintained for 1 of 3 sampled employees. (Employee #3) Findings include: On 11/20/23 in the afternoon, there was no file available for Employee #3 (E3). There was no documentation of the name, address, telephone number, social security number, date of hire, or reference checks for E3. There was no documentation of records related to training received by E3. Record review revealed there was no documented hire date for E3. The Office Manager reported the separation date for E3 was 10/21/23. On 11/20/23 in the afternoon, the House Manager indicated E3 was a Caregiver who worked at the facility for two weeks in October 2023 and the facility had not maintained a file for E3. The House Manager acknowledged the facility should have ensured E3 had a personnel file with all required documentation prior to employment. Severity: 2 Scope: 1	0100	Tag 0100 1. As separate personnel file will be made for each employee at the group home. All new hire paperwork will be complete and in the employee file going forward. 2. The House manager will complete a new employee file with all the required paperwork. The file will be kept on site, this will ensure the deficient practice does not recur. 3. The administrator will monitor all employee files on visits to group home. To ensure all files are complete and the deficient practice does not recur. 4. The administrator will be responsible for ensuring the plan of correction is implemented. 5. Date of Compliance: 1/2/2024	01/02/2024

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0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on document review, record review and interview, the facility failed to ensure 1 of 1 employees completed a five-year background check renewal for this facility. (Employee #2) Findings include: Employee #2 (E2) was hired on 01/01/11 as a House Manager/Caregiver. E2's record documented renewal fingerprinting and Nevada Automated Background Check System (NABS) Clearance Letters for another facility. Review of the NABS facility report on 11/20/23, confirmed E2 was not listed as an employee of this facility and eligible for employment. On 11/20/23 in the morning, E2 confirmed there was no renewed fingerprints and NABS Clearance Letter for E2 for this facility, per the requirement. Severity: 2 Scope: 1	0104	0104 1. A separate file will be kept for each employee.and will be in compliance with NRS. 449.122 to 449.125 Employee #2 date of hire 1/1/2011. The employee had fingerprints done from another facility. The employee#2 will get fingerprints completed under Golden Villa Care Home. (See Attached)We also will file the clearance letter in employee #2 file. 2. Staff must have fingerprints completed 10 days being employed with the group home. A fingerprint card, and clearance letter will be filed in employee file. 3. The administrator will monitor all employee files to ensure fingerprints are completed for the group home, this will ensure the deficient practice does not recur. 4. The administrator will be responsible for ensuring the plan of correction is implemented. 5. Date of compliance: 01/12024	01/11/2024
0840 SS= D	Review of Medical Condition of Resident - NAC 449.2738 Review of medical condition of resident; relocation or transfer of resident having certain medical needs or conditions. (NRS 449.0302) 1. If, after conducting an inspection or investigation of a residential facility, the Bureau determines that it is necessary to review the medical condition of a resident, the Bureau shall inform the administrator of the facility of the need for the review and the information the facility is required to submit to the Bureau to assist in the performance of the review. The administrator shall, within a period prescribed by the Bureau, provide to the Bureau: (a) The assessments made by physicians concerning the physical and mental condition of the resident; and (b) Copies of prescriptions for medication or	0840	Tag 0840 Review of Medical Condition 1. The administrator shall, within a period prescribed by the Bureau (five days), provide the Bureau: a. The current assessments made by physicians concerning the physical and mental condition of Resident #5. Resident #5 was seen by primary physician 11/28/23. (See Attached) b. Copies of current prescriptions for medication or orders of physician for services or equipment necessary to provide care for Resident #5. Resident #5 was discharged to family 12/2/23. (See attached) 2. The house manager will notify the	01/25/2024

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	orders of physicians for services or equipment necessary to provide care for the resident. Inspector Comments: Based on observation, document review, record review and interview, the Bureau of Health Care Quality and Compliance (HCQC) determined a current review by a physician of the physical and mental condition of 1 of 5 sampled residents was necessary. (Resident #5) Findings include: Resident #5 (R5) R5 was admitted to the facility on 02/05/23 with primary diagnoses including dementia, unsteady gait and hypertension. R5's Activities of Daily Living (ADL) Assessment dated 02/05/23, documented R5 was oriented to person and place and did not require protective supervision. R5's Facility Needs Assessment on 02/05/23, documented R5 was independent on all ADLs except laundry and medications and did not require protective supervision. R5's Standard Physician's Assessment on 02/23/23, documented R5 was oriented to person, place and time, Category I. R5's physical and mental condition was stable and following a predictable course. R5's Physician's Placement Determination dated 02/23/23, documented R5 required a residential facility that provided care to persons and protective supervision in accordance with the needs of a person suffering from old age or disabilities. R5's Standard Assessment for Cognitive Abilities on 03/15/23, documented R5 was not cognitively able to go on an outing on their own. On 11/20/23 at 10:45 AM, R5 explained R5 wanted to go for a walk and left their room and went out the front door. R5 walked down the street and saw a house R5 liked and knocked on the door. The occupant opened the door and R5 reported there were four people at the door. R5 described the people and R5 sat on the porch talking and they then invited R5 inside and R5 went in. R5 reported being at the neighbor's home for four hours. R5 reported		administrator immediately if any residents have a change of behaviors or condition. They will be seen by a physician to assess the necessary care for the resident. The administrator will notify HCQC and send paperwork. This will ensure the deficient practice does not recur. 3. The administrator on visits to Golden Villa will monitor all residents needs and report to residents physician to re- assess needs for proper care of the resident. 4. The administrator will be responsible for ensuring the plan of correction is implemented. 5. Date of compliance: 1/25/24	

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	R5 did not know why R5 left the facility. R5 reported R5 was wearing a pink robe, pink footies and no shoes. R5 realized it was getting dark and R5 thought R5 should go home. R5 did not know where R5 lived. A police officer walked R5 home and spoke to the caregiver about what had happened with R5. A Facility Incident Report dated 10/19/23 at 6:13 PM, documented R5 went missing from the facility and was later brought back to the facility by a police officer. The family and physician were notified. As of 11/20/23, there was no documented evidence the facility obtained a reassessment of R5 after a change in condition of wandering behaviors, to ensure R5 was still appropriate for the facility. E2 indicated R5 was alert and oriented to place and person, and recognized R5's behavior was declining. E2 confirmed R5 had a dementia diagnosis and required redirection. E5 confirmed the only assessment on record for R5 was the initial one at admission. The Administrator confirmed the facility did not have a policy on residents wandering. Severity: 2 Scope: 1 Complaint #NV00069787			