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 _____	**06/23/2025**

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 06/23/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was nine. The sample size was eight. The facility received a grade of A. There were three complaints investigated. Substantiated: 1. Complaint #NV00074336 was substantiated. (See TAG Y938) Substantiated Without Deficient Practice: 2. Complaint NV00073306 was substantiated without deficient practice. No regulatory deficiency found. Unsubstantiated: 3. Complaint #NV00073978 could not be substantiated. The investigation of the complaints included: Observation of grooming and physical appearance for residents, residents and interactions between residents and employees, observations for resident wandering and a tour of the facility. Interviews conducted with residents, a Caregiver, the Owner and the Facility Representative. Clinical record review of resident records, including residents of concern and three employee records. Document review of facility policies and procedures and Employee Staffing schedule. 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		
0938 SS= E	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential	0938	Tag 0938 1. Resident #5 - Failed to follow the ADL assessment for Resident #5 & #6. A new Activity of Daily Living Assessment was completed on 6/30/25. Resident #5 hair was washed and cut, staff will maintain by	08/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JOANNE MISURACA Title: Administrator Date: 08/04/2025

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	facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure an Activities of Daily Living (ADL) Assessment was followed for 2 of 8 residents. (Resident #5 and #6) Findings include: Resident #5 (R5) R5 was admitted on 09/10/22 with a primary diagnosis of congestive heart failure. R5's file documented an ADL Assessment dated 01/06/25. R5's annual ADL Assessment documented R5 was completely dependent on the facility for bathing, dressing, oral care and toileting. On 06/23/25 at 8:57 AM, R5 was observed with extremely matted hair. According to R5, the facility had not brushed or washed R5's hair in months. R5 verbalized it would be nice if the facility brushed R5's hair every other day and washed R5's hair every two weeks. On 06/23/25 at 11:50 AM, the Facility Representative reported R5's family member was to brush R5's hair and acknowledged the facility does not brush R5's hair regularly. On 06/23/25 at 12:10 PM, a Caregiver acknowledged not brushing R5's hair routinely and verbalized not having a brush for R5. According to the		washing and brushing. Resident #6- hair was washed and cut and staff to maintain hair. Resident #6 is on AllPro Hospice. (See Attached) 2. Staff will now review each ADL assessment of the residents and follow the Activity of Daily Living Assessment plan. The manager will ensure ADL's are completed and followed for the residents, this will ensure the deficient practice does not recur. 3. The administrator on visits to the group home will inspect all residents and check ADL assessments to ensure deficient practice does not recur. 4. The administrator will be person responsible for ensuring the plan of correction is implemented. 5. Date of compliance: 8/1/25	

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	Caregiver, R5's head was occasionally wiped down with a cloth to clean it. Resident #6 (R6) R6 was admitted on 05/07/25 with primary diagnoses including hemiplegia and muscle weakness. R6's file documented an ADL Assessment dated 05/07/25. R6's initial ADL Assessment documented R5 was to receive facility assistance with bathing, dressing, oral care and toileting. On 06/23/25 at 9:00 AM, R6 was observed with greasy, unbrushed hair. R6 reported the facility had not brushed R6's hair since arriving at the facility on 05/07/25. On 06/23/25 at 12:11 PM, a Caregiver acknowledged not having a brush for R6, and not brushing R6's hair. Severity: 2 Scope: 2 Complaint # NV00074336			

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0951 SS= D	Hospice Care Responsibilities of Staff - NAC 449.275 Residential facility which provides residents with hospice care: Responsibilities of staff; retention of resident with special medical needs. (NRS 449.0302) 2. The members of the staff of the facility shall: (a) Maintain at the facility a written record of the care and services provided to a resident who receives hospice care; and (b) Report any deviation from the established plan of care to the resident ' s physician within 24 hours after the deviation occurs. Inspector Comments: Based on document review, record review and interview, the facility failed to maintain home health records for 1 of 8 residents. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 11/05/24 with primary diagnoses including congestive heart failure, Parkinson's disease and dementia. R1 was enrolled with a home health agency. On 06/23/25 in the morning, R1's record lacked documented evidence of a home health record, including no documentation of physician's orders for services provided. On 06/23/25 at 11:30 AM, the Facility Representative confirmed there was no home health record on site for R1. Severity: 2 Scope: 1	0951	Tag 0951 1. The facility failed to maintain home health records for #R1. The records and plan of care were obtained and are now in the residents file.(See attached in Tag 0938 & 0951)for documents. 2. The staff was instructed and will maintain written records of the care and services provided to a resident who receives hospice or home health services. Staff is to report any deviation from the established plan of care to the resident's physician within 24 hours. 3. The administrator will monitor the residents records to ensure the deficient practice does not recur. 4. The administrator will ensure the plan of care is implemented. 5. Date of compliance: 6/30/2025	06/30/2025