

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 6414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/20/2026
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 RFG 0000- No Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. The RFG was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 04/20/26. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or Mental Illness, Category II residents. The census at the time of the survey was eight. The sample size was four. The facility received a grade of A. There was 1 complaint investigated. Unsubstantiated: 1. Complaint #NV00013456 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the Complaint included: Observation of meal service, food storage and supply, interactions between residents	ID PREFIX TAG RFG 0000- No Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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

Title:

Date:

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	and staff, and a tour of the facility. Interviews were conducted with residents and the Manager. Clinical Record Review of four records, which included the resident of concern. Document Review included facility policy and procedures, the facility's menu, the facility's incident log, and staff training.			