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 _____	**05/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LAKE CARE HOME	**9719 TUMBLE LAKE COURT, LAS VEGAS, NEVADA ,89147**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual state licensure survey and a complaint investigation completed in your facility on 05/29/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illnesses, five Category I and five Category II residents. The census at the time of the survey was ten. Ten resident files and five employee files were reviewed. The facility received a grade of B. Three complaints were investigated: Substantiated: 1. Complaint #NV00071294 was substantiated. See TAG Y174. 2. Complaint #NV00070902 was substantiated. See TAG Y830. Unsubstantiated: 3. Complaint #NV00070924 was unsubstantiated. The investigation into the complaints included: -Observations of the facility, pantry inventory, lunch meal preparation and service, and inspection for rodents and ants. -Interviews were conducted with the Owner/Operator, the Assistant Manager, one caregiver, a Hospice Registered Nurse, and seven residents. -Record review of ten residents, including the Residents of Concern. -Document review included menus, activity calendars, rate agreements, visitors' logs, and policies related to visiting hours, complaints/grievances, and valuables. 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. The following regulatory deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: SUSAN SOWERS Title: Administrator Date: 07/19/2024

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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0174 SS= F	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure the facility was 1) free from rodents and their droppings and 2) was clean and well-maintained. Findings include: On 05/29/24 at 12:30 PM, there were rodent droppings in three resident rooms, two closets, and the garage. Shelves in one kitchen cupboard next to the oven were covered with rodent droppings. Upon opening the bottom drawer of the oven, the floor was covered with rodent droppings. The following additional observations were made in the kitchen: - A black and brown substance was under the edge of the stove and between the stove and refrigerator. - The interior of the oven had grease and food debris covering it. - The top of the refrigerator was covered with dust and dirt. On 05/29/24 at 2:00 PM, eight of ten residents indicated they saw mice in their rooms and hallways. On 05/29/24 at 2:00 PM, a Caregiver, the Assistant Manager, and the Owner/Operator indicated they had a problem with mice at the facility for the last few months. The Owner/Operator verified they had not had a professional pest control company come to the facility to address the rodents. The Assistant Manager acknowledged the kitchen needed to be cleaned and sanitized. Severity: 2 Scope: 3 Complaint #NV00071294	0174	1. The facility immediately did the cleaning/sanitation on the same day. 2. All surfaces and storage areas that needed attention was done and will be monitored and be routinely clean. Pest Control agency was contacted to proceed with services. Services started immediately. 3. House manager will continue to keep facility clean, and routine cleaning are done. 4. Administrator will ensure the facility is to be maintain in good clean condition. Administrator will follow up with visits to make sure facility is kept in good condition so that the issue will not occur in the future. 5 Date of corrective action 6/6/2024 Rentokil Pest agency services has been contracted to take care of the facility. Date of completion 6/6/2024	06/06/2024
0515 SS= C	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall	0515	1. The Administrator established Person-Centered Service Plan for each resident. The service plans assessment was signed by each residents/responsible party.	06/05/2024

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	ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on interview and record review, the facility failed to develop a person-centered service plan for 10 of 10 residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10). Findings include: Resident #1 (R1) R1 was admitted to the facility on 04/11/24, with diagnoses including diabetes and chronic obstructive pulmonary disease. R1's file lacked a person-centered service plan. Resident #2 (R2) R2 was admitted to the facility on 03/18/24 with diagnoses including Parkinson's Disease. R2's file lacked a person-centered service plan. Resident #3 (R3) R3 was admitted to the facility on 04/24/24, with a diagnoses including chronic obstructive pulmonary disease and bipolar. R3's file lacked a person-centered service plan. Resident #4 (R4) R4 was admitted to the facility on 03/16/24, with a diagnoses including Alzheimer's Disease and hypertension. R4's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted to the facility on 02/17/23, with diagnoses including dementia and schizophrenia. R5's file lacked a person-centered service plan. Resident #6 (R6) R6 was admitted to the facility on 04/11/24, with diagnoses including dementia and hypertension. R6's file lacked a person-centered service plan. Resident #7 (R7) R7 was admitted to the facility on 12/03/21 with diagnoses including dementia and hypertension. R7's file lacked a person-centered service plan. Resident #8 (R8) R8 was admitted to the facility on 01/02/24, with a diagnoses including failure to thrive and		The said Person-Centered Plan was signed and filed in each resident's files. 2. The Administrator or facility representative will assess residents upon admission to established the Person-Centered Plan with new residents. 3. Administrator will monitor that this Person-Centered Service will be implemented for all future residents and re assessment will be done annually. 4 Administrator will be responsible for ensuring the plan is implemented to ensure compliance 5. The Administrator stablished the plan on 6/5/2024	

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	benign prostatic hyperplasia. R8's file lacked a person-centered service plan. Resident #9 (R9) R9 was admitted to the facility on 05/21/24, with a diagnoses including cerebral palsy and hypertension. R9's file lacked a person-centered service plan. Resident #10 (R10) R10 was admitted to the facility on 08/16/16, with diagnoses including chronic obstructive pulmonary disease. R10's file lacked a person-centered service plan. On 05/29/24 in the afternoon, the Assistant Administrator acknowledged person-centered service plans were not developed for R1, R2, R3, R4, R5, R6, R7, R8, R9, and R10. Severity: 1 Scope: 3			

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0620 SS= D	Written Policy on Admissions - NAC 449.2702 and R043-22 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on observation, interview and record review, the facility failed to obtain a medical exemption to maintain a resident who was bedfast (Resident #2). Findings include: Resident #2 (R2) R2 was admitted to the facility on 03/18/24 with diagnoses including Parkinson's Disease. On 05/29/24 in the morning, R2 was observed laying bed and unable to demonstrate the ability to turn from side to side in bed without assistance. The Caregiver verified R2 could not turn from side to side without assistance and the Caregiver explained R2 had to be turned every two hours. Review of R2's record lacked documented evidence of an approved bedfast medical exemption from the Bureau. On 05/29/24 in the morning, the Assistant Administrator acknowledged R2 was bedfast and did not have an approved bedfast medical exemption on file. Severity: 2 Scope: 1	0620	1. A waiver was submitted and approved for the resident on 6/11/2024 (Please see attached) 2. The Facility administrator will ensure that a bedfast and or wound-care waiver or any other waivers will be submitted if and when the resident requires one. 3. Administrator will monitor to make sure that the waiver is completed in a timely manner and submitted once a resident is required to have one. 4. Administrator is responsible for ensuring the plan of correction is implemented to stay in compliance. 5. Date of correction action was 6/11/24	06/11/2024

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0830 SS= D	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on observation, interview and record review, the facility failed to obtain a medical exemption to maintain a resident with an open wound (Resident #2). Findings include: Resident #2 (R2) R2 was admitted to the facility on 03/18/24 with diagnoses including Parkinson's Disease. On 05/29/24 in the morning, R2 was observed lying in bed and was unable to clearly communicate. On 05/29/24 in the morning, the Caregiver verbalized R2 was admitted from the hospital with multiple wounds and skin issues. The Caregiver verbalized hospice came in three times a week to care for R2's wounds. The Caregiver verbalized turning and repositioning R2 every two hours. Review of R2's record revealed hospice notes documenting three wounds. The first was an unstageable wound on R2's shoulder, the second was a stage four wound on R2's buttocks, and the third was an unstageable wound on R2's left heel. The Hospice documentation noted wound care was completed three times a week and the wounds were unresolved. The intake information from the Hospice documentation revealed R2 was admitted to the facility with the three wounds and other related skin issues from the hospital. R2's file lacked an approved medical exemption from the Bureau for R2's wounds. On 05/29/24 in the morning, the Assistant Administrator acknowledged R2 did not have an approved medical exemption on file. Severity: 2 Scope: 1 Complaint #NV00070902	0830	1. The waiver was submitted and accepted to retain the resident with prohibited conditions. 2. Administrator will put in practice that a resident with prohibited condition must have the waiver submitted to the health department as soon as the resident requires one. 3. The facility Administrator will ensure to submit an exemption request for a resident/patient from restriction or retain to admit at the facility according to the regulations of the NAC 449.271 to 449.2734. 4 Administrator will monitor and make sure facility is incompliance with the regulations for exemption requests waivers 5. Date of completion was on 6/17/24	06/17/2024

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1830 SS= D	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the secondary infection control designee completed 15 hours of infection control training from a nationally recognized organization (Employee #2). Findings include: Employee #2 (E2) E2 was hired on 06/1/19 as a Caregiver. E2's file lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. On 05/20/24 in the afternoon, the Assistant Administrator acknowledged E2 was the secondary infection control program designee. The Assistant Administrator acknowledged E2's file lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. Severity: 2	1830	1. The Facility implemented Infection Control Training for the staff in accordance with the regulations. 2. Staff received online training in May 23,2024, May 25,2024 and May 27,2024(please see certificates attached) 3. Administrator will make sure all staff will follow the regulations and receive training and certificates. 4. The administrator will ensure that all staff will receive the Infection Control Training and all certificates will be kept in staffs personal files. 5. Date of correction on 5/27/24	05/30/2024

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	Scope: 1			
1840 SS= F	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 3 employees received infection control training through a nationally recognized course (Employees #3, #4, and #5). Findings include: Review of the following employee records lacked documented evidence infection control training was completed through a nationally recognized course. Employee #3 was hired on 01/01/11, as the Assistant Administrator. Employee #4 was hired on 07/05/16, as a Caregiver. Employee #5 was hired on 009/16/23, as a Caregiver. On 05/29/24 in the afternoon, the Assistant Administrator acknowledged employees #3, #4, and #5 did not receive infection control training through a nationally recognized course. Severity: 2 Scope: 3	1840	1. Staff received Infection Control Training Certificates. 2. The administrator will make sure to check the completion of the required training will be on the file of each individual caregiver. 3 Administrator will monitor that staff receives Infection Control Traning. 4. Administrator will be responsible for ensuring that the plan of correction will be implemented. 5. First Person Training 5/19/2024 Second person Training 5/23/2024 3rd Person (Assist Manger) 5/27/2024	05/30/2024