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 _____	**05/20/2025**

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

(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 an annual state licensure survey and a complaint investigation completed in your facility on 05/20/25, 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 seven. Eight resident files and three employee files were reviewed. The facility received a grade of A. Two complaints were investigated: Substantiated: 1. Complaint #NV00074074 was substantiated. (See TAG Y557). Unsubstantiated: 2. Complaint #NV00073293 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaints included: Observations of residents being ambulated through the facility, residents in wheelchairs, residents hygiene well maintained, lack of odors, residents cognitive ability and use of half rails on resident beds. Interviews were conducted with the Owner, a Nurse Practioner, Caregivers and residents. Clinical Record review of eight residents, including the Residents of Concern. Document review included facility 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 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: RFA Date: 05/27/2025

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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0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on interview and document review, the facility failed to ensure a tuberculosis (TB) screening,was completed annually, for 1 of 3 employees (Employee #2). Findings include: Employee #2 (E2) was hired on 06/12/19 as a Caregiver. Review of E2's employee record revealed E2 last completed an annual TB screening on 01/11/24. There was no documentation E2 completed an annual TB screening in the past 12 months. On 05/20/25, in the morning, a Caregiver confirmed E2 had not completed an annual TB screening in the past 12 months. Severity: 2 Scope: 1	0102	1. The deficiency will be corrected by the facility coordinator/designated employee immediately requesting a screening of the "Signs and Symptoms" for employee #2 as required for the personal file. 2. To ensure the deficiency will not happen again, the designated employee will ensure that the files of all employees are reviewed monthly to check for when all forms and certificates are due. 3. Facility administrator will monitor all employees files on visits to ensure that files are updated prior to the expiration date. 4. Administrator and designated employee are responsible for implementing regulations. 5. Action was completed on 5/21/25 - See attached document for employee #2.	05/21/2025
0557 SS= E	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation, interview and record review, the facility failed to ensure bed rails were not used on residents who were cognitively impaired, and unable to lower the rail without staff assistance, for 2 of 7 residents (Resident #1 and Resident #2). Findings include: Resident #1 (R1) R1 was admitted on 02/17/23 with dementia and schizophrenia. R1 was unable to properly verbalize answers to questions, due to cognitive decline. R1's bed was observed	0557	1. The deficiency will be corrected by the designated employee/staff immediately removing the bed rails due to being a confinement and restraint for all residents that are cognitively impaired and unable to manipulate the lowering the rails. 2. Upon admission of a resident, the administrator and the designated employee/staff members will ensure to remove bed rails of all residents that are unaware and unable to properly use without any assistance. If there is a decline in a resident that is capable of currently using a bed rail, that resident would be reassessed to see if they are still cognitively capable and physically capable of manipulating the bed rail. 3. The facility administrator will ensure that all residents that are to be admitted that require a hospital bed, check that bed rails	05/21/2025

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	against the wall on one side. Review of R1's medical record revealed R1 was bedfast and could not turn side to side or move around in bed. Resident #2 (R2) R2 was admitted on 01/04/24 with diagnosis including chronic obstructive pulmonary disorder and type 2 diabetes mellitus. R2 was non-verbal and unable to answer questions. R2's bed was observed with a half rail up on one side, and against the wall on other side. Review of R2's medical record revealed R2 was bedfast and could not turn side to side or move around in bed. On 05/20/25, in the morning, a Caregiver indicated they normally leave R1 and R2's half rail in the up position while they are in bed, to prevent R1 and R2 from falling out of bed. On 05/20/25, in the morning, the Owner confirmed they use a half rail for R1 and R2 as a fall precaution even though R1 and R2 are bedfast and can not move around in bed. The Caregiver confirmed they use a half bed rail for R1 and R2, and R1 and R2 cannot put the bed rails down on their own. Severity: 2 Scope: 2 Complaint #NV00070483		are not included unless residents are cognitively able to verbalize the right and safety use and not for restrain or confinement. 4. Administrator and facility staff are responsible of ensuring and implementing the regulation. 5. Corrective action done 5/21/25	