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 _____	**07/28/2025**

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 a complaint investigation completed in your facility on 07/28/25, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups The census at the time of the survey was ten. The sample size was five. The facility received a grade of A. There were two complaints investigated. Substantiated: 1. Complaint #NV00074743 was substantiated - see TAG Y0556. Substantiated without deficient Practice: 2. Complaint #NV00074519 was substantiated with no deficient practice. The investigation of complaint included: Observation of interactions between caregivers and residents, caregivers providing care to residents and a tour of the facility. Interviews were conducted with the Residents of Concern, residents, Caregivers, the Administrator and the Owner. Record Review of five records, which included the residents of concern. Document Review included facility policy and written communication with a Resident of Concern's family member. 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 deficiency was identified:	0000		
0556 SS= D	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) 2. If an employee of the facility suspects that a resident is being abused, neglected, isolated or exploited, the employee shall	0556	1. To correct this deficiency, residents in the facility are to be treated with respect and dignity. In any case of suspected abuse, staff will immediately report to manager and administrator for immediate corrective action. Manager/administrator will do due diligence to investigate and report to proper authority. 2. To make sure that this deficiency will not recur, all staff are to follow the newly	07/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: SUSAN SOWERS Title: RFA Date: 09/12/2025

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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	report that fact in the manner prescribed in NRS 200.5093. Inspector Comments: Based on interview and document review, the facility failed to report the suspected abuse of the residents to the local office of Aging and Disability Services (ADSD). Findings include: On 07/28/25 in the morning, Resident #4 (R4) reported about a week and a half ago, Resident #2 (R2) politely asked for a metal knife from Employee #3 (E3), instead of a plastic knife. According to R4, E3 went to the kitchen and threw a metal knife across the table to R2. R4 reported the knife would have hit R2 if R2 bent forward. On 07/28/25 in the morning, a second resident reported E3 was bothered anytime a resident would ask E3 for assistance. Approximately one week ago, E3 threw a metal knife across the table when R2 requested a metal knife instead of a plastic knife. According to this resident, R2 would have been hit in the head with the metal knife had they moved forward at the table. On 07/28/25 in the morning, a third resident reported E3 was often in a bad mood and very short with residents. About a week ago, this resident observed R2 request a metal knife from E3 in the dining room. E3 went to the kitchen and threw the knife across the table at R2. On 07/28/25 in the morning, the facility lacked documented evidence a report was made to the office of ADSD regarding E3's knife throwing incident. On 07/31/25 in the morning, the Owner reported being aware of the incident where E3 threw a metal knife at R2 because residents verbalized the incident involving E3 occurred and confirmed the facility failed to submit a report to ADSD, per the requirement. On 07/31/25 in the morning, the Owner provided the Nevada Health Authority a copy of the facility's Elder Abuse Policy. The Facility's Elder Abuse Policy did not document the facility was to report suspected abuse to ADSD. 1. The policy documented any suspected or known abuse		revised "Elder Abuse Policy". (Please see attached document.) The new "Elder Abuse Policy" includes that APS/ADSD is to be notified within 24 hours of any type of elder abuse. 3. Monitoring will be done by staff and manager and or administrator to ensure the residents are safe and that no abuse will take place. Also staff is to encourage all residents to voice any concerns to us concerning their care or how staff is treating them. 4. Persons responsible are caregivers, manager, and administrator. 5.. Date of corrective action was on 7/21/2025	

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	will be made to a supervisor or a designated administrator but lacked evidence it addressed the regulatory requirement (NRS 200.5093) regarding the duty to report the allegation to the local office of Aging and Disability Services as soon as practicable and in no case later than 24 hours after learning of the incident. Severity: 2 Scope: 1 Complaint #NV00074743			