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 _____	**08/07/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS CASTLE HOME OF FERNLEY	**575 FARM DISTRICT ROAD, FERNLEY, NEVADA ,89408**

(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 initiated at your facility on 08/07/20. This State investigation was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The census at the time of investigation was 15. Complaint #NV00061661 with the following allegation could not be substantiated. Allegation #1: Staff not wearing Protective Personal Equipment (PPE). As a result, a resident was admitted to a hospital with COVID-19. Complaint #NV00061638 with the following allegations could not be substantiated. Allegation #1: Staff not wearing PPE while entering a room on isolation precautions. As a result, a resident was admitted to a hospital with COVID-19. Allegation #2: Staff possibly exposed residents to COVID-19. Allegation #3: The facility threatened to evict the resident. The investigation into the allegations included: Observation of staff utilizing PPE, staff to resident interactions, and cleaning practices within the facility. Interviews were conducted with a Caregiver. Document review included hospital records, facility policies on visitation requirements, COVID-19 plan, infection prevention policies, PPE inventory, and COVID-19 test results. 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. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report for your records.	0000		

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

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.