

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2020	
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS CASTLE HOME OF FERNLEY				STREET ADDRESS, CITY, STATE, ZIP CODE 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 conducted at your facility on 10/19/20. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 16. 20 resident records, including four closed records, and nine employee records were reviewed. There was one complaint investigated. Complaint# NV00062267 with the following allegations could not be substantiated: Allegation #1: male staff members would giggle while showering female residents could not be substantiated based on lack of document evidence and resident and staff interviews. Allegation #2: male staff members would rub up against or lie on female residents could not be substantiated based on observation, lack of document evidence and resident and staff interviews. Allegation #3: a staff member was verbally and physically abusive to a resident could not be substantiated based on observation, lack of document evidence and resident and staff interviews. The investigation into the allegations included: Observations of residents in their rooms, in the dining area, and in the living room. Interviews were conducted with three residents, three Caregivers, and the Administrator. Reviewed 20 resident records, including four closed records, nine staff records, and incident reports dated from 02/19/20 to 10/18/20. 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 investigations, 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 required. Please retain a copy for your records.	0000					

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

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.