

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9883	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2022
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS MEMORY CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8920 LOGGERS MILL AVE, LAS VEGAS, NEVADA ,89143		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure survey for an endorsement addition conducted at your facility on 09/02/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight Residential Facility for Group beds with endorsements for elderly or disabled persons and/or persons with chronic illnesses, Category II residents. The facility has applied for an endorsement to provide care for adults with Alzheimer's disease. The census at the time of survey was seven. Four employee files were reviewed. The facility received a grade of A. 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. The following regulatory deficiency was identified.			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Name: LAWRENCE DENNIS O'SHEA	Title: Administrator	Date: 09/22/2022
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(X4) ID PREFIX TAG 1035 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 1035	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 09/01/2022
	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (1) Within the first 40 hours that such an employee works at the facility after he or she is initially employed at the facility, at least 2 hours of training in providing care, including emergency care, to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease, and providing support for the members of the resident ' s family. Inspector Comments: Based on interview and record review, the facility failed to ensure two hours of Alzheimer's initial training was completed for 1 of 4 employees (Employee #4) within 40 hours of hire. Employee #4 was hired on 08/01/22. There was no documentation of Alzheimer's training for Employee #4. A Caregiver confirmed there was no documented Alzheimer's training in the record of Employee #4. The facility was unable to provide documentation of Alzheimer's training for Employee #4 within 72 hours Severity: 2 Scope: 1		1) Conducted required training 2) Check all employee training certificates to make sure they are up to date 3) Administrator and head caregiver to monitor 4) Administrator 5) 9/1/22 6) see attached	