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 _____ | **10/24/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **VALLEY OF GOLDEN AGES** | **2680 MARGARET DR., RENO, NEVADA ,89506** |

| (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<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation survey conducted at your facility on 10/24/24. This survey was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for six Residential Facility for Groups beds for elderly and disabled persons, and/or Alzheimer's disease, Category II residents. The census at the time of the survey was six. Two resident files and two employee files were reviewed. The facility received a grade of A. There were two complaints investigated. Complaint #NV00071906 with the following allegations could not be substantiated due to lack of sufficient evidence: Allegation #1: The facility failed to provide a clean and working environment for residents. Allegation #2: The facility failed to maintain the proper temperature range per regulation, resulting in the temperature inside being too hot. Allegation #3: The facility failed to maintain a safe environment for residents due to lighting and temperatures not within regulation. The investigation into the allegation included the following: Observation of staff to resident interactions, and staff cleaning bathrooms and kitchen area. Interviews were conducted with one resident, one Caregiver, and the Administrator. Review of two employee files and two resident files, including the resident of concern. Document review included incident reports, ADL logs, admission agreements, care plans, history and physicals and placement determinations. Complaint #NV00070921 with the following allegations could not be substantiated due to lack of sufficient evidence: Allegation #1: The facility failed to maintain a safe environment resulting in a resident eloping from the facility. Allegation #2: The facility failed to report after a | 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.

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 _____ | **10/24/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **VALLEY OF GOLDEN AGES** | **2680 MARGARET DR., RENO, NEVADA ,89506** |

| (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 |
|---|---|---|---|---|
| | resident successfully eloped from the facility. Allegation #3: The facility failed to ensure that all employees were up to date on background checks and cultural competency trainings. Observation of staff to resident interactions and resident activities. Interviews were conducted with one resident, one Caregiver, and the Administrator. Review of two employee files and two resident files, including the resident of concern. Document review included incident reports, ADL logs, admission agreements, care plans, history and physicals and placement determinations. 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 necessary. Please retain a copy for your records. | | | |