STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3382	A. BUILDING _____ B. WING _____	08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN MEADOWS RESIDENTIAL	4119 MEADOWGLEN CIRCLE, LAS VEGAS, NEVADA ,89121

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RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a mandatory re-grading survey initiated at your facility on 08/13/26. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or mental illness, Category II residents. The census at the time of the survey was six. Five resident files and five employee files were reviewed. The facility received a grade of A.			
Y 0515 SS= D	NAC 449.259 **Supervision of residents.** 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of	Y 0515	1) The Administrator/designee reviewed Resident #2's Person Centered Service Plan and updated the plan to reflect the resident's current condition and need for repositioning every two hours. 2) The facility has implemented a process requiring staff to notify the Administrator/designee when a resident experiences a change in condition or develops a new care need. The Person Centered Service Plan will be reviewed and updated when a change in condition occurs to ensure all required services, including repositioning, are documented in the resident's individualized care plan. 3) Caregivers and appropriate facility staff will be educated on recognizing and reporting changes in a resident's condition and the requirement to ensure new or changed service needs are reflected in the resident's Person Centered Service Plan. Staff will also be instructed to follow and document all interventions identified in the resident's plan of care. 4) Administrator 5) 08/19/2026 6) Updated Person Centered service plan for Resident #2 Personal Care & Repositioning Log Schedule of Turns	08/19/2026

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	the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on interview and record review, the facility failed to ensure an individualized care plan included documentation of service provisions for a resident who needed repositioning every 2 hours. (Resident #2) Findings include: Resident #2 (R2) R2 was admitted to the facility on 11/11/23 with a diagnosis of congestive heart failure. R2's file revealed a Person-Centered Service plan dated 11/11/25. R2's 11/11/25 Person Centered Service Plan failed to document R2 needed repositioning every 2 hours.			

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	On 08/13/26 in the morning, a Caregiver verbalized staff began turning and documenting R2's repositioning every 2 hours beginning on 08/05/26 due to R2's declining conditioning after a hospital stay in late July of 2026. The Caregiver acknowledged R2's 11/11/25 plan of care lacked documented evidence that R2's condition had declined and R2 required repositioning every 2 hours. Severity: 2 Scope: 1			
Y 0557 SS= D	**NAC 449.262 and R043-22** **Provisions of dental, optical and hearing care and social services; report of suspected abuse, neglect or exploitation; restriction on use of restraints, confinement or sedatives.** 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or (c) Provide sedatives to a resident unless that sedative has been prescribed for that resident by a physician, physician assistant or advanced practice registered nurse to treat specific symptoms. A caregiver shall make a record of the behavior of a resident who has been prescribed a sedative. Inspector Comments: Based on observation and interview, the facility failed to ensure bed rails were not used on a resident who was cognitively impaired, and unable to lower the rail without staff assistance, for 1 of 5 sampled residents (Resident #2).	Y 0557	1) The Administrator/designee immediately reviewed the use of the half bed rail for Resident #2. The half bed rail was lowered and will remain in the lowered position at all times for Resident #2. Staff were instructed not to leave the bed rail in a raised position for Resident #2. 2) All bed rails are in a lowered position for Resident #2. All caregivers were educated that all bed rails need to be in a lowered position unless a resident is able to raise it or lower it themselves. 3) The Administrator/designee will conduct routine audits of resident rooms and records to verify that bed rails are being used appropriately and that residents using bed rails are able to safely operate/release them as required. Any concerns identified during monitoring will be immediately addressed and documented. 4) Administrator 5) 8/19/2026 6) No Restraint Policy	08/19/2026

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	Resident #2 (R2) R2 was admitted to the facility on 11/11/23 with a diagnosis of congestive heart failure. R2 was asked a series of questions by the surveyor, however the resident appeared to be unable to answer the questions. R2's bed was observed with a half rail up on one side, and against the wall on other side. R2 could not turn side to side or move around in bed. On 08/13/26 in the morning, a Caregiver confirmed they use a half bed rail for R2, and R2 could not lower the bed rails on R2's own. Severity: 2 Scope: 1			
Y 0620 SS= E	NAC 449.2702 and R089-24 4. Except as otherwise provided in this section and NAC 449.2736 and 449.275, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; (d) Requires skilled nursing or other medical supervision on a 24-hour basis; (e) Requires gastrostomy care; (f) Requires vacuum-assisted wound closure therapy; (g) Requires dialysis, if the person is unable to leave the facility to obtain dialysis services;	Y 0620	1) On 08/19/2026, the Administrator submitted Bedfast Medical Exemption applications to the Bureau for Residents #2 and #3. The facility will maintain documentation of the applications and any correspondence and approvals received from the Bureau in each resident's record. 2) The facility has implemented a policy requiring caregivers to reposition/turn bedfast residents at least every two hours, as ordered and clinically appropriate. Caregivers will document each repositioning in the resident's record/turning schedule. The Administrator or designee will monitor documentation for compliance. 3) Hospice has provided care plans for Residents #2 and #3. Facility staff will follow the hospice care plans and ensure applicable interventions are incorporated into the residents' care and documented accordingly. 4) Administrator 5) 08/19/2026 6) Bedfast Medical exemption applications submitted for Resident #2 and #3 Hospice Care Plans for Resident #2 and #3	08/19/2026

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	(h) Suffers from a serious staphylococcus infection or other serious infection; or (i) Suffers from any other serious medical condition or requires care not described in NAC 449.2712 to 449.2734, inclusive. 5. A residential facility that provides care to persons with Alzheimer's disease or other severe dementia, as described in paragraph (a) of subsection 2 of NRS 449.1845, may admit or retain a resident who requires confinement in locked quarters. 6. If a governmental entity with jurisdiction, including, without limitation, a local board of health, a local health officer, the Division, the Chief Medical Officer or the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, declares the existence of an epidemic or pandemic, a residential facility located in the area in which the epidemic or pandemic is occurring may permit a resident suffering from a serious infection to remain a resident if the resident does not have symptoms that require a higher level of care than the residential facility is capable of providing. 7. A person may not reside in a residential facility if the person's physician or the Bureau determines that the person does not comply with the requirements for eligibility. 8. As used in this section, "restraint" means: (a) A psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical			

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	symptoms; (b) A manual method for restricting a resident's freedom of movement or the resident's normal access to his or her body; or (c) A device or material or equipment which is attached to or adjacent to a resident's body that cannot be removed easily by the resident and restricts the resident's freedom of movement or the resident's normal access to his or her body. **Reference - R089-24 Sec. 9.** "Bedfast" means: 1. Incapable of changing his or her position in bed without the assistance of another person; or 2. Immobile. Inspector Comments: Based on interview and record review, the facility failed to obtain a medical exemption to maintain two residents who were bedfast (Resident #2 and #3). Findings include: Resident #2 (R2) R2 was admitted to the facility on 11/11/23 with a diagnosis of congestive heart failure. On 08/13/26 in the morning, R2 was unable to demonstrate the ability to turn from side to side in bed without assistance. R2's file lacked documented evidence of an approved bedfast medical exemption from the Bureau. Resident #3 (R3) R3 was admitted to the facility on 06/26/25			

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	with a diagnosis of cerebral atherosclerosis. On 08/13/26 in the morning, R3 was unable to demonstrate the ability to turn from side to side in bed without assistance. R3's file lacked documented evidence of an approved bedfast medical exemption from the Bureau. On 08/13/26 in the morning, a Caregiver confirmed R2 and R3 were unable to turn from side to side in bed without assistance and acknowledged R2 and R3 did not currently have an approved bedfast medical exemption on file. Severity: 2 Scope: 2			
Y 0930 SS= E	NAC 449.2749 **Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.** 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident.	Y 0930	1) The Administrator/designee reviewed the ADL Assessments for Residents #2 and #3. The ADL Assessments have been updated to accurately reflect each resident's current functional needs, including the requirement for repositioning every two hours. The updated assessments will be maintained in each resident's record and used by caregivers when providing services. 2) The facility has implemented a process requiring ADL Assessments to be reviewed and updated whenever there is a change in a resident's condition or functional status that affects the services the resident requires. Staff are required to report changes in condition or newly identified care needs to the Administrator/designee so the resident's ADL Assessment can be reviewed and updated. 3) The Administrator/designee will conduct periodic audits of ADL Assessments to verify that residents' current functional needs and required services are accurately documented. The audit will include verification that repositioning requirements and other changes in ADL needs are reflected in the resident's assessment and that staff are providing and documenting the services identified. 4) Administrator 5) 8/19/2026 6) Schedule of Turns Log personal care & repositioning log Updated ADL Assessments for Resident #2 & 3	08/19/2026

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	(b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him. (c) A statement of the resident's allergies, if any, and any special diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. (f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a			

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	brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i)The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility. 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was			

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	discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death. 3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau. Inspector Comments: Based on interview and record review, the facility failed to ensure the ADL (Activities of Daily Living) assessment included documentation of service provisions for two residents who needed repositioning every 2 hours. (Resident #2 and #3) Findings include: Resident #2 (R2) R2 was admitted to the facility on 11/11/23 with a diagnosis of congestive heart failure. R2's file revealed an ADL Assessment dated 07/22/26. R2's 07/22/26 ADL Assessment failed to document R2 needed repositioning every 2 hours. On 08/13/26 in the morning, a Caregiver verbalized staff began turning and documenting R2's repositioning every 2 hours beginning on 08/05/26 due to R2's declining conditioning after a hospital stay			

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	in late July of 2026. The Caregiver acknowledged R2's 07/22/26 ADL Assessment lacked documented evidence that R2 required repositioning every 2 hours. Resident #3 (R3) R3 was admitted to the facility on 06/26/25 with a diagnosis of cerebral atherosclerosis. R3's file revealed an ADL Assessment dated 06/20/26. R2's 06/20/26 ADL Assessment failed to document R2 needed repositioning every 2 hours. On 08/13/26 in the morning, a Caregiver verbalized staff began turning and documenting R3's repositioning every 2 hours since April of 2026. The Caregiver acknowledged R3's 06/20/26 ADL Assessment lacked documented evidence that R2 required repositioning every 2 hours. Severity: 2 Scope: 2			