Division of Public and Behavioral Health

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 _____	01/08/2020

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

(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 State licensure annual survey conducted in your facility on 01/08/20. This State licensure survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illnesses, Category II residents. The census at the time of the survey was seven. Seven resident files were reviewed and 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	0000		
0830	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on observation, record review and interview, the facility failed to obtain a bedfast exemption for 1 of seven residents (Resident #1). On 01/08/2019 in the afternoon, Resident #1 verbalized they were not able to turn themselves in the bed any longer, and required assistance from staff to reposition. Severity: 2 Scope: 1	0830	A The Administrator immediately requested documents from the hospice agency and fax it to the division of Public Behavioral Health. On January 21, 2020 tag 0830 see attachment 1, A, B , C and D B. The administrator shall apply for a bed fast waiver when there conditions changes. C. Accomplished January 21, 2020	01/29/2020

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: JANET ROQUE Title: Administrator Date: 01/25/2020