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
	3483	A. BUILDING _____ B. WING _____	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE	1905 S 17TH STREET, LAS VEGAS, NEVADA ,89104

(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 an annual State Licensure survey completed at your facility on 07/07/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category II residents. The census at the time of the survey was eight. Eight resident files 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	0000		

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: CHERRY DAELTO Title: Administrator Date: 07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3483	A. BUILDING _____ B. WING _____	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE	1905 S 17TH STREET, LAS VEGAS, NEVADA ,89104

(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
0430 SS= F	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: Based on observation and interview the facility failed to ensure fire extinguishers were checked annually. Findings include: On 07/07/2025 at 8:44 AM, fire extinguishers located in the common area and the kitchen did not have a current tag confirming they were inspected within the past year. On 07/07/2025 at 11:03 AM, the owner confirmed the two fire extinguishers had not been inspected within the past year. Severity: 2 Scope: 3	0430	1. Facility fireextinguishers at common area and the kitchen were both serviced. 2. By way ofreminders on the monthly calendar to annually serviced fire extinguisher. 3. Checking ourcalendar monthly we will be able to do the things that need to be done to staycurrent. 4. The facility managerwill monitor.	07/07/2025
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of	0878	1. The facility conducted a meeting immediately to make sure all employees understand the importance of providing all residents with medication as prescribed by the resident physician. 2. During the facility meeting all employees were reminded to call or fax the pharmacy refill request form for medication that are low in quantity like 5 tablets left to avoid resident run out of prescription medication. Also, employees were instructed to initial medication in the medication administration sheet (MARS) if medication was administered to the resident only and not falsely initial if medication is not administered. Lastly, call the pharmacy to remind them if they are	07/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3483	A. BUILDING _____ B. WING _____	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE	1905 S 17TH STREET, LAS VEGAS, NEVADA ,89104

(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
	subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation and interview the facility failed to ensure medication was administered per physician's orders for 1 of 8 sampled residents (Resident #7). Findings include: Resident #7 (R7) R7 was admitted to the facility on 06/11/2024 with a diagnosis of Dementia. A physician's order dated 07/01/2024 documented Donepezil 10 Milligrams (mg) take one tablet by mouth once daily. On 07/07/2025 in the morning R7's medication bin contained an empty bottle of the medication Donepezil 10 mg 30-day supply dated 05/28/2025. The July 2025 Medication Administration Record (MAR) documented Donepezil 10 mg daily. The MAR was completed as if the		not delivered the next day to ensure timely delivery of medication. 3. By this way the facility will be able to track medication that needs refill or are zero (0) refill thus having an ample time for the pharmacy & or patient family to call resident physician on medication that needs to be refill. 4. The facility administrator will monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3483	A. BUILDING _____ B. WING _____	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE	1905 S 17TH STREET, LAS VEGAS, NEVADA ,89104

(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
	medication was being administered from 07/01/25 to 07/06/25. On 07/07/2025 in the morning, the Caregiver indicated the MAR was filled out in advance for the Donepezil 10 mg and the medication was not administered. On 07/07/2025 in the morning, the caregiver verbalized the medication Donepezil 10 mg was not administered per the physician's order from 07/01/2025 to 07/06/2025 because the facility had forgotten to refill R7's prescription. Severity: 2 Scope: 1			