

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 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER ANGELS HOUSE ADULT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5496 TAMARUS STREET, LAS VEGAS, NEVADA ,89119	
(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 an annual State licensure and complaint investigation survey completed in your facility on 03/28/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Requirements for Residential Facilities 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 seven. Eight resident files and four employee files were reviewed. The facility received a grade of A. One complaint was investigated: Unsubstantiated. 1. Complaint #NV00070514 was unsubstantiated. No regulatory deficiencies could be identified. The investigation into the allegations included: -Observations of residents and staff providing dignified care and assistance. -Interviews were conducted with the Administrator, two Owner/Operators, residents, and a Caregiver. -Clinical record review of five residents, including the resident of concern. -Document review included Resident Rights, the Resident Admission Agreement, Visitor Logs, and Hospice documentation. 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. There were no regulatory deficiencies identified. No action is necessary. Retain this Statement for your records.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name:
REPRESENTATIVE'S SIGNATURE

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.