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
	4367	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE OF MONACO ANGEL PARK	**8617 HIGHLANDVIEW AVE, LAS VEGAS, NEVADA ,89145**

(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 03/26/25 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was six. Six resident files and five 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: EDWIN VALENTIN Title: Administrator Date: 04/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4367	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE OF MONACO ANGEL PARK	8617 HIGHLANDVIEW AVE, LAS VEGAS, NEVADA ,89145

(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
0104 SS= F	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on interview and record review, the facility failed to ensure a background check was completed through the Nevada Automated Background Check System (NABS) for the current facility for 3 of 5 employees (Employees #3, #4, and #5). Findings include: Employee #3 (E3) E3 was hired as a Caregiver on 09/08/23. On 03/26/25 in the afternoon, E3's employee file lacked documented evidence a background check was completed through NABS for the facility. Verification through the NABS online system confirmed E2 completed fingerprints and background check on 07/17/23 for a different facility. Employee #4 (E4) E4 was hired as a Caregiver on 02/07/25. On 03/26/25 in the afternoon, E4's employee file lacked documented evidence a background check was completed through NABS for the facility. Verification through the NABS online system confirmed E4 submitted fingerprints for a different facility on 01/14/25 and was cleared to work at that facility; however, a NABS clearance letter specific to Grace of Monaco Angel Park was not in E4's file. Employee #5 (E5) E5 was hired as a Caregiver on 04/30/21. On 03/26/25 in the afternoon, E5's employee file lacked documented evidence a background check was completed through NABS for the facility. Verification through the NABS online system confirmed E2 completed fingerprints and background check on 01/15/25 for a different facility. On 03/26/25 in the afternoon, the Caregiver was unable to produce evidence E3, E4, and E5 completed background checks through NABS for the facility. Severity: 2 Scope: 3	0104	Tag 0104 BACKGROUND CHECK - PERSONNEL FILE. A) A background check for employee #3,4,5 for the facility has been completed. * PLEASE SEE ATTACHED DOCUMENTS. B) Whenever a new hired employee of the facility before duty, a background check will be completed through NABS. Result will be filed in the employee personnel file. The Administrator will monitor for compliant. C) 3/27/2025	03/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4367	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE OF MONACO ANGEL PARK	8617 HIGHLANDVIEW AVE, LAS VEGAS, NEVADA ,89145

(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
0106 SS= D	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 5 employees received in-person cardiopulmonary resuscitation (CPR) and first aid training (Employee #5). Findings include: Employee #5 (E5) E5 was hired on 04/30/21 as a Caregiver. E5 completed CPR and first aid training provided by an online company on 05/09/23. The training through this company did not contain an in-person component, a requirement per the regulation. On 03/25/25 in the afternoon, the Caregiver acknowledged the CPR and first aid training completed by E5 did not contain an in-person component, and verbalized it was their understanding that online-only courses for subsequent trainings after the first in-person training were acceptable. Severity: 2 Scope: 1	0106	Tag 0106 FIRST AID AND CPR. A) A first aid and CPR with in-person component has been scheduled on 5/09/2025 at Medic One located at 5651 Centennial Blvd. Las Vegas, NV. 89149. B) Whenever a caregiver is hired in the facility, a first aid and CPR with in-person component will be completed prior to employment. Certificate will be file in the employee personnel file. A log will be obtain to make sure certificate will be competed prior to expiration date. Administrator will monitor for compliant. C) 4/08/2025 C) 4/08/2025	04/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4367	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE OF MONACO ANGEL PARK	8617 HIGHLANDVIEW AVE, LAS VEGAS, NEVADA ,89145

(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
0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 6 residents or their Power of Attorney (POA) had signed an Ultimate User Agreement, granting permission to the facility to assist in the administration of the resident's medication (Resident #5). Findings include: Resident #5 (R5) R5 was admitted on 02/14/24 with diagnoses including senile degradation of the brain, coronary artery disease, hypertension and Dementia. R5's resident file lacked documented evidence of an Ultimate User Agreement. The March 2025 Medication Administration Record documented the facility administered R5's medications. On 03/26/25 in the afternoon, the Caregiver acknowledged R5 was missing a signed Ultimate User Agreement, and indicated R5's POA did not cooperate with the facility's efforts to update R5's records. Severity: 2 Scope: 1	0876	Tag 0876 MEDICATION ADMINISTRATION. A) An Ultimate User Agreement from resident #5 POA has been obtained granting permission to the facility to assist in the administration of resident medication. * PLEASE SEE ATTACHED DOCUMENT. B) Whenever a resident is admitted to the facility, a medication ultimate agreement will be obtained from POA/PATIENT granting permission to assist resident in administering medication. The Administrator will monitor for compliant. C) 3/27/2025	03/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4367	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE OF MONACO ANGEL PARK	8617 HIGHLANDVIEW AVE, LAS VEGAS, NEVADA ,89145

(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
1840 SS= E	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 5 employees completed the annual required infection control training for unlicensed caregivers (Employees #2 and #5). Findings include: Employee #2 (E2) E2 was hired as a Caregiver on 09/29/09. E2's file lacked documented evidence of the required infection control training provided by a nationally recognized organization. E5 was hired as a Caregiver on 07/30/21. E5's file lacked documented evidence of the required infection control training provided by a nationally recognized organization. On 03/26/25 in the afternoon, the Caregiver confirmed E2 and E5 did not complete the required annual infection control and prevention training. Severity: 2 Scope: 2	1840	Tag 1840 UNL CAREGIVER TRAINING. (INFECTION CONTROL). A) An infection control training for employee #2 and 5 has been completed from a nationally recognized organization. (CDC). * PLEASE SEE ATTACHED DOCUMENTS. B) An infection control to all unlicensed caregivers will be completed annually provided by a nationally recognized organization. The administrator will monitor for compliant. C) 4/01/2025	04/01/2025