

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2023
NAME OF PROVIDER OR SUPPLIER THE ROYAL PLACE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3644 MOUNTCREST DRIVE, 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 an annual, complaint investigation, and infection control State Licensure survey completed at your facility on 03/02/23, 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 illness, and/or persons with chronic illness, Category II residents. The census at the time of the survey was eight. The facility received a grade of A. The sample size was nine. There was one complaint investigated. Unsubstantiated: 1. Complaint #NV00067731 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the Complaint included: Observations of caregivers not sleeping in or residing in resident closets and residents moving freely around the facility. Interviews were conducted with residents and caregivers. Record Review of eight records, which included the resident of concern. Document Review included posted mealtimes, grievance log, employee driver's licenses with addresses not reflecting the address of the facility. 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. No regulatory deficiencies were identified. No further action necessary. Please retain a copy for your records.	0000		

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.