

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 05/13/2021	
NAME OF PROVIDER OR SUPPLIER ANGEL CARE RESIDENTIAL HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 5559 TROOPER STREET, LAS VEGAS, NEVADA ,89120			
(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 complaint investigation conducted at your facility on 05/13/2021, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 10. The sample size was three. The facility received a grade of A. One complaint was investigated. Complaint #NV00063676 with one allegation was unsubstantiated. Allegation #1 - The facility failed to obtain and maintain sufficient Worker's Compensation Insurance was unsubstantiated based on interviews conducted with a Caregiver, the Administrator, and the Owner who denied the facility lacked sufficient Worker's Compensation Insurance. A review of an active policy indicated the facility had current Worker's Compensation Insurance. The investigation into the allegation included: Interviews with a Caregiver, the Administrator, and the Owner. Documentation review of a current Worker's Compensation Insurance policy for 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. There were no regulatory deficiencies 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.