

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2021
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 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 and infection control State Licensure survey conducted at your facility on 09/02/21, in accordance with Nevada Administrative Code, Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 10. Ten resident records and six employee records were reviewed. The facility received a grade of A. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of nondiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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. No regulatory deficiencies were identified. No further action necessary. Please retain a copy for your records.			

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 Name: _____ Title: _____ Date: _____
REPRESENTATIVE'S SIGNATURE