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
	7543	A. BUILDING _____ B. WING _____	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE RESIDENTIAL HOME	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 an annual State Licensure survey conducted at your facility on 06/05/25, 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 persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. Eight resident files and six 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 investigation, 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		
0104 SS= D	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 record review and interview, the facility failed to ensure 1 of 6 employees had a background check clearance through the Nevada Automated Background Check System (NABS) for this facility. (Employee #1) Findings include: Employee #1 (E1) E1 was hired on 12/01/24 as the Administrator. E1's record lacked documented evidence of a NABS Clearance letter for this facility. On 06/05/25 at 11:40 AM, the Administrator confirmed there was no NABS Clearance letter for E1 and it was for another facility. On 06/05/25 in the afternoon, E1 was not listed in the Bureau's NABS database for this facility. Severity: 2 Scope: 1	0104	1) We have corrected the deficiency by having employee #1 complete the background check procedures, and by placing the clearance letter in the employee folder. 2) All employees are required to have the background check completed regardless of whether the employee needs to complete fingerprinting or not. This was an oversight that was corrected (see attachment) 3) We will monitor this deficiency by checking the employee spreadsheets monthly to verify all required documents have been logged, including those of an Administrator. 4) The Administrator will be responsible for implementing this POC. 5) Date of completion: 06/20/2025 6) Attachment to include Clearance Letter for Background check EE#1.	06/20/2025
0830 SS= F	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may	0830	1) We have corrected the deficiency by completing waiver exemptions for the residents #1, 4, & 6. 2) We will better utilize H&P information in	06/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7543	A. BUILDING _____ B. WING _____	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE RESIDENTIAL HOME	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
	submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure a medical exemption request was submitted to the Bureau to retain three residents who were bedfast. (Resident #1, #4 and #6) Findings include: Resident #1 (R1) R1 was admitted on 06/01/21 with primary diagnoses including dysphagia following a cerebral infarction, Alzheimer's disease and left side hemiplegia. R1 was admitted to a Hospice agency on 05/28/23. On 06/05/25 in the morning, physical examinations dated 05/15/24, 12/23/24 and 05/15/25, noted R1 as bedfast. R1's record documented provisional bedfast waivers dated 05/18/23 and 05/20/24. There was no documented evidence of a bedfast waiver application for R1 for 2025. On 06/05/25 at 9:35 AM, the Administrator confirmed there was no bedfast waiver application for 2025 and explained the facility was waiting on a new resident admission to apply for the waivers at the same time. Resident #4 (R4) R4 was admitted on 12/17/20 with primary diagnoses including heart failure, atherosclerosis, dementia, shortness of breath and obesity. R4 was observed sleeping during multiple observations on 06/05/25. On 06/05/25 in the morning, an annual physical examination dated 10/11/24, documented R4 was bedfast. On 06/05/25 in the morning, R4's record documented an approved bedfast waiver dated 03/26/21. R4's record documented a waiver application on 05/11/24. There was no documentation of approval of the 05/11/24 waiver request. On 06/05/25 in the morning, there was no documented evidence of a bedfast waiver application for R4 for 2025. On 06/05/25 at 10:25 AM, the Administrator confirmed the lack of a 2024 and 2025 bedfast waiver for R4. The Administrator reported as of 06/02/25, the facility was waiting for Hospice agency information for R4 to submit a bedfast		the future to locate a waiver needed diagnosis prior to admittance of new residents, and our in-house ADL assessment once they are admitted to better determine the need for State exemptions. 3) We will monitor the corrective action by keeping our resident spreadsheet up to date in order to monitor when a waiver is expiring so that we can re-certify prior to the annual expiration dates. We will also monitor those residents needing a change of condition to see if any change also requires a new waiver from the State. 4) The Administrator will be responsible for implementing this plan. 5) Correction Date: June 24, 2025 6) Attachments: 3 Bedfast waivers (RES #1,4,6)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7543	A. BUILDING _____ B. WING _____	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE RESIDENTIAL HOME	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
	waiver request. Resident #6 (R6) R6 was admitted on 10/08/21 with primary diagnoses including Alzheimer's disease and hyperanxiety disorder. On 06/05/25 in the morning, R6 was observed lying in bed and was unable to answer questions regarding R6's condition due to cognition. On 06/05/25 in the morning, R6's record documented a bedfast waiver application on 05/18/24, with a provisional approval dated 05/20/24. It was noted in R6's record of the request for a new Plan of Care from the Home Health agency. There was no approval letter documented in R6's record. On 06/05/25 in the morning, an annual physical examination dated 04/30/25, documented R6 was confined to the bed. On 06/05/25 in the morning, there was no documented evidence of a bedfast waiver application for R6 for 2025. On 06/05/25 at 10:50 AM, the Owner and Administrator confirmed E6 was not currently receiving Home Health agency services. The Administrator confirmed R6 should have had a bedfast waiver for 2024 and a new waiver request for 2025, and there were no waivers in R6's file. On 06/05/25 in the morning, the Administrator reconfirmed the lacked of documented evidence of 2024 and 2025 bedfast waiver applications and/or approvals for R1, R4 and R6. Severity: 2 Scope: 3			
1825 SS= D	Designation/Training persons for IC Program - NAC 449.0109 Designation and training of person responsible for infection control. 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers	1825	1) We have corrected the specific finding by EE#1 completing the annual requirement of infection control training and making sure the certificates are in the employee's folder (see attachment). 2) We have the infection control requirements listed on our annual list in each employee folder, including the requirements for the primary and Secondary infection Control Personnel. This deficiency was an administrative oversight. 3) New hires and current employees coming due for their annual trainings will be reminded by the Administrator 30 days prior to the training due dates. This will be possible by the updated employee spreadsheets that the Administrator keeps on each employee. 4) The Administrator will be responsible for	06/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7543	A. BUILDING _____ B. WING _____	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE RESIDENTIAL HOME	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
	for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary infection control designee completed the initial 15 hour infection control and prevention training. (Employee #1) Findings include: Employee #1 (E1) E1 was hired on 12/01/24, as the Administrator/Primary Infection Control Designee. E1's file lacked documented evidence of initial 15 hours of infection control and prevention training from a nationally recognized organization. On 06/05/25 in the afternoon, the Administrator confirmed the required infection control and prevention training from a nationally recognized organization had not been completed for E1 and should have been. Severity: 2 Scope: 1		implementing this correction. 5) Correction date: 06/15/2025 6) Attachments: CDC Infection Control Certificates (15-hour training)	