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
	9189	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL PALACE	**3131 ROSANNA ST, LAS VEGAS, NEVADA ,89117**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of the State Licensure Annual survey conducted at your facility on 09/02/21, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly or disabled persons with endorsements for Assisted Living services, chronic illness, and Alzheimer's disease or related dementia, Category 2 residents. The census at the time of the survey was eight. Eight resident records and four employee files were reviewed. The facility received a grade of D. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination 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 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: GEOFFREY GOMEZ Title: Administrator Date: 11/05/2021

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0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on interview and employee record review, the facility failed to ensure infection control practices were implemented and maintained in response to the COVID-19 pandemic. Findings include: There was no documented evidence employees had N95 mask FIT testing and medical clearance. The Owner / Operator acknowledged none of the employees had FIT testing and medical clearance to wear an N95 mask. Severity: 2 Scope: 3	0050	N95 fit test completed 12/17/2020. Administrator will schedule yearly N95 fit test per regulations and file in proper binder for documentation to ensure it doesn't get missed again. Administrator will review staff files monthly. Administrator will monitor for compliance.	10/27/2021

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0065 SS= F	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Inspector Comments: Based on interview and employee record review, the facility failed to ensure 3 of 4 employees had annual training in caring for the needs of the residents (Employee #2, #3, and #4). Findings include: The following employees lacked documentation of training in annual caregiving: -Employee #2 (E2) E2 began employment as a Caregiver on 05/16/19. There was no documented evidence of annual training for E2. Employee #3 (E3) E3 began employment as a Caregiver on 10/24/19. There was no documented evidence of annual training for E3. Employee #4 (E4) E4 was the Owner / Operator and Caregiver with a start date of 05/25/19. There was no documented evidence of annual training for E4. On 09/02/21 the Administrator confirmed E2, E3, and E4 lacked annual training in caregiving for elderly or disabled persons. Severity: 2 Scope: 3	0065	E2, E3, E4 Caregiving completed 10/1/21. Administrator will review employee files every six months to ensure training is completed in a timely manner. Administrator will monitor for compliance.	10/01/2021
0074 SS= F	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility	0074	E2, E3, E4-Elder Abuse training completed 9/30/21. Administrator will review employee files every six months to ensure training is completed in a timely manner. Administrator will monitor for compliance.	09/30/2021

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	for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual			

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	abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on interview and employee record review, the facility failed to ensure 3 of 4 employees had			

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	annual training in elder abuse prevention (Employee #2, #3, and #4). Findings include: Employee #2 (E2) E2 began employment as a Caregiver on 05/16/19. There was no documented evidence of annual training for E2. Employee #3 (E3) E3 began employment as a Caregiver on 10/24/19. There was no documented evidence of annual training for E3. Employee #4 (E4) E4 was the Owner / Operator and Caregiver, with a start date of 05/25/19. There was no documented evidence of annual training for E4. On 09/02/21 the Administrator confirmed E2, E3, and E4 lacked annual training in elder abuse prevention. Severity: 2 Scope: 3			
0102 SS= E	Personnel File - TB Screening - NAC 449.200 Personnel files. 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on interview and employee record review, the facility failed to ensure tuberculin (TB) testing was completed in accordance with Nevada Revised Statutes (NRS) Chapter 441A for 2 of 4 employees (Employee #2 and #4). Findings include: Employee #2 (E2) E2 was employed as a Caregiver on 05/16/19. The last TB testing was dated 06/22/20, with no results documented. There was no documentation of annual TB testing. Employee #4 (E4) E4 was the Owner / Operator and Caregiver, with a start date of 05/25/19. The last TB testing was a QuantiFERON test dated 09/08/19, with negative results. There was no documentation of annual TB testing. The Administrator acknowledged there was lack of documented annual TB testing for two employees. Severity: 2 Scope: 2	0102	E2-9/22/21, E4-9/16/21 TB test completed. Administrator will review employee files every month to ensure TB test is completed in a timely manner and ensure files are in the proper binder for easy access. Administrator will monitor for compliance.	09/22/2021

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0106 SS= F	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 interview and employee record review, the facility failed to ensure 3 of 4 employees had current certification in first aid and cardiopulmonary resuscitation (CPR) (Employee #2, #3, and #4). Findings include: There was no documented evidence of current certification in first aid and CPR for the following employees: - Employee #2 (E2) was employed as a Caregiver on 05/16/19. The first aid and CPR certification expired on 03/08/20. - Employee #3 (E3) was employed as a Caregiver on 10/24/19. The first aid and CPR certification expired on 05/16/21. - Employee #4 (E4) was the Owner / Operator and Caregiver, employed on 05/25/19. The first aid and CPR certification expired on 09/08/20. On 09/02/21, the Administrator verified Employee #2, #3, and #4 were the primary caregivers at the facility and lacked current first aid and CPR. Severity: 2 Scope: 3	0106	E2, E3, E4 First Aid/CPR completed 10/9/21. Administrator will review employee files every six months to ensure training is completed in a timely manner. Administrator will monitor for compliance.	10/09/2021

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0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on interview and record review, the facility failed to ensure the medication regimen was reviewed every six months for 1 of 8 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 01/06/20 with diagnoses including dementia, diabetes mellitus, and chronic kidney disease. There was no documented medication regimen review completed for R1 within the past six months. The last documented medication review signed by a physician, registered nurse, or pharmacist was dated 07/22/20. The Caregiver acknowledged there was no medication regimen review conducted every six months for R1. Severity: 2 Scope: 1	0870	R1 medication review completed 9/20/21. Administrator will review residents files monthly ensure accuracy. New residents will require administrator file review prior to admit. Administrator will monitor for compliance.	09/30/2021
0878 SS= E	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has	0878	R3-MAR August/September corrected to reflect giving during those month. Administrator will review MAR monthly ensure medications are recorded properly as well as new patients admitted to the facility. R4-Memantine corrected to reflect right dosage. The doctor order was	10/28/2021

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	approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure physician's orders were followed for 3 of 8 residents (Resident #3, #4, and #6). Findings include: Resident #3 (R3) R3 was admitted to the facility on 10/08/20 with diagnoses including coronary artery disease and hyperlipidemia. The medication box for R3 contained Donepezil, 5 milligrams (mg), 1 tablet per day, filled on 07/07/21. The Medication Administration Record (MAR) for August and September of 2021 did not list the Donepezil. The Caregiver verified the		changed 6/17/2021. Administrator will review MAR monthly to ensure doctor's order's are recorded and documented in a timely manner. R6-Meloxicam discontinued 9/3/21, family can't afford medication. Administrator provided In-house staff training medication follow up. Staff to follow-up medication not received in 24 hours after physician's order and notify administrator. And document in MAR "NOTE" time/date nurse/doctor was notified of the issue. Administrator to review monthly residents MAR files. Administrator will monitor for compliance.	

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	physician ordered the Donepezil on 07/07/21, and the Donepezil was not administered to R3, for the period of 08/01/21 through 09/01/21. Resident #4 (R4) R4 was admitted to the facility on 03/23/20 with diagnoses including end stage renal disease, hypertension, and benign prostate hypertrophy. The physician's order dated 04/07/20 documented Memantine, 5 mg, 1 tablet twice daily. The MAR for August and September of 2021 indicated the Memantine was only administered once a day. The Caregiver acknowledged the Memantine should have been administered twice daily per the physician's order. Resident #6 (R6) R6 was admitted to the facility on 08/28/21 with diagnoses including dementia. The physician's order dated 08/28/21 indicated Meloxicam, 15 mg each day. There was no Meloxicam available for R6. The Caregiver and a Hospice Nurse verified R6 was admitted with a physician's order for the Meloxicam. The Caregiver indicated the Meloxicam was not obtained from the pharmacy, and R6 was not administered the medication as prescribed, for the period of 08/28/21 through 09/02/21. Severity: 2 Scope: 2			
0936 SS= F	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on interview and record review, the facility failed to provide documentation of the tuberculin (TB) testing requirements for 5 of 8 residents (Resident #1, #2, #3, #5, and #6).	0936	R1-TB test completed 1/22/21. R2-TB test completed 10/13/21. R3-TB test completed 10/5/21. R5-2 step TB test completed 3/24/21. Administrator will review new residents document prior to admit to the facility ensure files are complete and accurate. Administrator will review residents file monthly and ensure documents are filed properly. Administrator will monitor for compliance.	10/30/2021

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	Findings include: Resident #1 (R1) R1 was admitted to the facility on 01/06/20 with diagnoses of chronic kidney disease and dementia. The last TB testing was a Quantiferon TB test dated 12/05/19 (negative results). There was no documentation of annual TB testing. Resident #2 (R2) R2 was admitted to the facility on 07/31/20 with diagnoses including diabetes and congestive heart failure. The last TB testing was dated 07/17/20 and 07/24/20, with negative results and no read dates. Resident #3 (R3) R3 was admitted to the facility on 10/08/20 with diagnoses including coronary artery disease and hypertension. TB testing documentation showed a one-step Mantoux TB test administered on 09/03/21 with no read results. There was no evidence of a two-step TB test. Resident #5 (R5) R5 was admitted to the facility on 03/12/21 with diagnoses including dementia and atrial fibrillation. There was no evidence of initial two-stepTB testing. Resident #6 (R6) R6 was admitted to the facility on 08/28/21 with diagnoses including dementia. There was no evidence of initial two-step TB testing. On 09/02/21, the Owner / Operator and the Administrator acknowledged R1, R2, R3, R5 and R6 lacked documentation of TB testing per NRS 441A. Severity: 2 Scope: 3			
0938 SS= F	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a	0938	R1-ADL completed 9/29/21. R2-ADL completed 9/29/21. R3-ADL completed 9/29/21. R4-ADL completed 9/29/21. R8-ADL completed 9/29/21. Administrator will review residents file every month to ensure ADL is completed and documented accordingly. Administrator will monitor for compliance.	10/30/2021

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(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
	change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and record review, the facility failed to ensure assessments for activities of daily living (ADL's) were completed for 5 of 8 residents (Resident #1, #2, #3, #4, and #8). Findings include: Resident #1 (R1) R1 was admitted to the facility on 01/06/20 with diagnoses including dementia, chronic kidney disease, and hypertension. There was no documented evidence of an annual ADL assessment for R1. The most recent documented ADL assessment was dated 01/06/20. Resident #2 (R2) R2 was admitted to the facility on 07/31/20 with diagnoses including diabetes mellitus and congestive heart failure. There was no documented evidence of an annual ADL assessment for R2. The most recent documented ADL assessment was dated 07/31/20. Resident #3 (R3) R3 was admitted to the facility on 10/08/20 with diagnoses including coronary artery disease and hypertension. There was no documented evidence of an initial ADL assessment for R3. Resident #4 (R4) R4 was admitted to the facility on 03/23/20 with diagnoses including end stage renal disease and hypertension. There was no documented evidence of a dated ADL assessment for R4. Resident #8 (R8) R8 was admitted to the facility on 01/19/19 with diagnoses including congestive heart failure and hypertension. There was no documented evidenced of annual ADL assessments for R8. The most recent documented ADL assessment was dated 01/19/19. The Administrator acknowledged the ADL assessments were missing for R1, R2, R3, R4, and R8. Severity: 2 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9189	A. BUILDING _____ B. WING _____	09/02/2021

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0994 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation, the facility failed to ensure sharp objects were not accessible to residents. Findings include: On 09/02/21, the following sharp objects were not locked up and were accessible to residents: - Razors were accessible in two Resident Bathrooms. -The backyard shed was not locked. There were sharp tools including needle nose pliers and a pick axe stored in the shed. -There was a shovel and rake in the back yard. The Administrator and the Owner/Operator acknowledged the sharp objects were not secured in a locked area and were accessible to residents. Severity: 2 Scope: 3	0994	Two Resident bathrooms and staff bathroom lock added. Backyard shed pad lock added. Administrator provided staff in-house training NAC 499.2756, NRS 449.0302. Administrator to review monthly facility environment safety protocol. Administrator will monitor for compliance.	10/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9189	A. BUILDING _____ B. WING _____	09/02/2021

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0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation, the facility failed to ensure toxic substances were not accessible to residents. Findings include: On 09/02/21, the following toxic substances were available to residents: -Employee Bathroom: Two Bio Clean spray bottles and one container of Septic Cleaner. -Office: one Raid spray can. On 09/02/21 the Owner / Operator acknowledged the doors to the Office and the Employee Bathroom were not locked and the toxic substances were accessible to residents. Severity: 2 Scope: 3	0999	Staff bathroom cabinet locked installed. Office door posted sign "DOOR MUST BE LOCK AT ALL TIMES". Administrator provided staff in-house training NAC 449.2756 and NRS 449.0302 safety protocol. Administrator to assess and review safety protocol once a month. Administrator will monitor for compliance.	10/04/2021