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 _____	10/22/2025

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

(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
RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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 _____	10/22/2025

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

(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
	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed at your facility on 10/22/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 10. The facility received a grade of A. There was one complaint investigated. <u>Substantiated:</u> 1. Complaint#NV00012213 was substantiated. (See Tag Y0557) The investigation of the complaint included: Observation of bed rails. Interviews were conducted with residents, Caregivers, hospice nurse, and the Administrator. Record Review of residents, which included the resident of concern. Document Review included incident reports.			

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 _____	10/22/2025

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

(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
	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.			
Y 0557 SS= D	**NAC 449.262 and R043-22** **Provisions of dental, optical and hearing care and social services; report of suspected abuse, neglect or exploitation; restriction on use of restraints, confinement or sedatives.** 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or (c) Provide sedatives to a resident unless that sedative has been prescribed for that resident by a physician, physician assistant or advanced practice registered nurse to treat specific symptoms. A caregiver shall make a record of the behavior of a resident who has been prescribed a sedative. Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure 1 of 10 residents (Resident #10) was free from physical restraints.	Y 0557	Resident #10 passed away on 11/3/2025. Administrator and/or Designee reviewed all other Residents beds to ensure compliance on 11/15/2025 with bed rails and any residents needing rails for support getting in and out of bed only will have doctor orders going forward or no bed rails.	11/03/2025

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 _____	10/22/2025

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

(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
	Findings include: Resident #1 (R10) R10 was admitted on with a diagnosis of dementia. The Activities of Daily Living (ADL) assessment dated07/25/25, documented R10 needed full assistance with all ADL's. On 10/22/25 in the morning, R10 was observed in bed sleeping with a quarter bed rail on each side of the bed. R10 was sleeping and was not available for interview. R1's file documented R10 had cognitive decline and required total staff assistance for mobility and transfers. A hospice physician's order dated 07/16/25, documented bedrails were provided by hospice. The order did not specify which size. No documented evidence was found of a medical symptom necessitating the use of bedrails or an assessment demonstrating the resident's ability to safely use or self-release from them. On 10/22/25 at 9:55 AM, Caregiver #1 (C1) indicated R1 was confused and did not know how to lower the bed rails and staff lowered them forR1 as needed. C1 communicated R1 originally had full bed rails and tried to climb over them and occasionally still did once the facility changed them to quarter rails. The hospice nurse recently changed R1's medications and now R1was calm and did not frequently try to climb over the rails. On 10/22/25 at 10:10 AM, Caregiver #3 (C3) did not know whether the resident could lower the bed rails. On 10/22/25 at 10:30 AM, the hospice nurse ordered the bedrails and originally R1 had full sided bed rails and upon the facility's request changed them to quarter rails. The hospice nurse acknowledged R1 was trying to climb over the bed rails and R1 did not know how to lower the bed rails when needed.			

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 _____	10/22/2025

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

(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
	On 10/22/25 at 1:30 PM, the Administrator reported the facility replaced the full bed rails with quarter rails at the beginning of August 2025 after determining full rails were not permitted. The Administrator indicated a trapeze bar was requested to replace the bed rails since the resident did not know how to lower the rails and was trying to climb over them. Severity: 2 Scope:1			