

Division of Public and Behavioral Health

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                     |                                                                                                                          |                                                        |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>4367</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/09/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRACE OF MONACO ANGEL PARK</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>8617 HIGHLANDVIEW AVE, LAS VEGAS, NEVADA ,89145</b> |                                                                                                                          |                                                        |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br><b>0000</b>                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG<br><br><b>0000</b>                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                             |
|                                                                       | <p>Initial Comments -</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 10/9/17. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was six. Six resident files were reviewed and seven 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 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 at this time. Please retain a copy for your records.</p> |                                                                                                     |                                                                                                                          |                                                        |

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