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 _____	01/29/2026

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		

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	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 mandatory State Licensure grading resurvey completed at your facility on 01/29/26, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for ten 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 eight. Two resident files and one employee file were reviewed. The facility received a grade of A. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance 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 0172 SS= F	NAC 449.209 2. Containers used to store garbage	Y 0172	Plan of Correction, POC TAG #Y172 2) What measures or systematic change(s)	06/26/2026

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	outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. 4. To the extentpracticable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained.		will be put intoplace to ensure the deficient practice does not recur *Policy Revision & Vendor Agreement: The facility has revised and updatedits Environmental Safety Policy. To ensure consistent compliance, a mandatoryservice contract with our waste management vendor has been verified andenforced, guaranteeing that outdoor refuse containers are emptied and all wasteis removed from the premises at least once per week. *Staff Re-education & Training: All facility personnel—including kitchen,laundry, housekeeping, and caregiving staff—have completed mandatory re-educationregarding proper waste disposal regulations. Training specifically emphasizedthe strict requirement of keeping all designated indoor and outdoor refusecontainers securely covered at all times. *Implementation of Daily EnvironmentalChecklist: A structured daily "Environmental and Pest ControlChecklist" has been operationalized for housekeeping and dietary staff.This checklist strictly mandates the inspection of all areas to ensure thepremises remain clean, free from offensive odors, clear of mobilityhazards/obstacles, and free from any dirt or refuse accumulation. 3) How the corrective action(s) will be monitored to ensure the deficientpractice will not recur Daily Quality Assurance Rounds: The designatedsupervisor or designee will conduct daily environmental rounds utilizing thenewly implemented checklist. These rounds will verify that all kitchen,laundry, and applicable resident bedroom/bathroom trash receptacles areproperly covered, and that outdoor bins are securely sealed.	

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	Inspector Comments: Based on observation and interview, the facility failed to ensure the exterior of the facility was free from hazardous items. Findings include: On 01/29/26 at 9:45 AM, observed 6 - 15" by 15" tiles making a path into the backyard. The tiles were sitting on top of the landscape rocks and were a tripping hazard. Observed rakes, a hoe and 9 or 10 long and short poles in an enclosed space. The gate to this space was open, giving access to the dangerous items. Observed a bottle of unknown chemicals in the enclosed space. On 01/29/26 at 9:50 AM, the Caregiver confirmed the observations and agreed the tiles were a tripping hazard. This was a subsequent deficiency from the 07/26/25 annual State Licensure survey. Severity: 2 Scope: 3		Weekly Administrative Audits: The Facility Administrator will conduct formalweekly audits encompassing the interior, exterior, and landscaping maintenanceto ensure continuous adherence to clean premises and safety regulations. QAPI Oversight & Reporting: Auditfindings and checklist logs will be documented and submitted monthly to theQuality Assurance and Performance Improvement (QAPI) Committee for review overthe next three (3) consecutive months. If 100% compliance is sustainedthroughout this period, the monitoring frequency will transition to randommonthly spot-checks. 4) The title of the person (position) responsible for ensuring the plan ofcorrection is implemented: Primary Responsibility: FacilityAdministrator Support Staff: Environmental Services/Housekeeping Supervisor and KitchenManager 7) How other areas having potential to be affected by thesame deficient practice will be identified and corrected: Facility-Wide Environmental Scan: The administration has executed acomprehensive, facility-wide environmental scan to identify and mitigate anyother potential waste, odor, or pest vulnerabilities. Common Area & Perimeter Review: All common areas, hallways, exteriorwalkways, and landscaping zones were meticulously reviewed to ensure the totalabsence of obstacles impeding resident mobility and zero accumulation ofrefuse. Immediate Correction & Integration: Any minor discrepancies identifiedduring the scan were corrected immediately. These	

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			areas have now been fullyintegrated into the permanent daily maintenance and monitoring schedule to prevent future recurrence.	
Y 0995 SS= F	**NAC 449.2756 andR043-22** (f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor activities; (2) Has at least40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times Inspector Comments: Based on observation and interview, the facility failed to ensure gates leading to the street were secured. Findings include: On 01/29/26 at 9:30 AM, during a tour of the exterior of the home, observed the north	Y 0995	PLAN OFCORRECTION: TAG #Y 0995 **1) Correction of Specific Finding(s)** *Immediate Action Taken: On the day the deficiency was identified, the facilityimmediately secured and locked the north gate leading to the street. *Key Management: All emergency access keys have been properly stored andorganized. All on-duty staff and caregivers have been granted immediate,unrestricted access to these gate keys to ensure strict compliance withemergency egress requirements. **2) Systematic Changes to Prevent Recurrence** *Daily Check Mechanism: The facility has developed and implemented a formal*Daily Perimeter Security Checklist*. Caregiverson every shift are now required to physically inspect and verify that all gatesleading to unsecured areas or public streets (including the north gate) arefully locked during shift handoffs. *Staff Retraining: Mandatory retraininghas been initiated for all current and newly hired employees, includingcaregivers, regarding **Nevada Administrative Code (NAC 449.2756)**. Thistraining strictly emphasizes the critical importance of maintaining locked yardperimeter gates at all times and reinforces compliant key storage protocols. *Visual Warnings: Conspicuous, weather-resistant warning signs have beenpermanently posted on the interior of	06/26/2026

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	gate that let out to the street was unlocked. On 01/29/26 at 9:30 AM, the Caregiver confirmed the observation, verbalizing the gate was usually locked. The Caregiver acknowledged the gate should have been locked. Severity: 2 Scope: 3		all perimeter gates, reading: Keep GateClosed and Locked at All Times. **3) Monitoring of Corrective Actions** *Log Review: The Facility Supervisor (or designated QA lead) will review the*Daily Perimeter Security Checklist* on a weekly basis to verify consistent,timely, and compliant completion. *Random Audits: Facility Management will conduct unannounced, randomspot-checks of all external gate locking statuses across different shifts (day,evening, and night shifts) and formally document the findings. *Quality Assurance (QA) Integration: Perimeter security and gate compliance metricswill be added as a standing agenda item in the monthly Quality Assurance andPerformance Improvement (QAPI) meetings. Monitoring will be sustained for aminimum of 3 to 6 consecutive months. Any identified deviation from compliancewill trigger immediate corrective action and retraining. **4) Responsible Position** *Position Title: Facility Administrator / Director orResidential Facility Manager *(Note: Per regulatory guidelines, only the position title is listed, andpersonal names are omitted.)* **5) Completion Date** *Target Completion Date: July 31, 2026 (This date reflects the completion of all physical modifications, formdevelopment, and staff training prior to the projected revisit.) **6) Supporting DocumentationAttached**	

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			The facility will upload the following supporting evidence into the NevadaDepartment of Health and Human Services (DHHS) system along with this report: * Photographs of the secured/locked north gate and the designated key storagelocation. * A blank sample and the recently completed records of the newly implemented*Daily Perimeter Security Checklist*. * Staff training sign-in sheets and the training curriculum/content outlinefocused on gate security and **NAC 449.2756** compliance. * Photographs of the "Keep Locked" warning signs posted on allperimeter gates. **7) Identification and Correction of OtherPotential Risk Areas** *Comprehensive Audit: The Facility Administrator has conducted a comprehensiveaudit of the entire facility perimeter, yard, and fencing to identify all othergates leading directly to external, un-secured areas (e.g., south gate, rearyard access). *Unified Corrective Action: All identified gates and potential risk areas havebeen fully integrated into the daily inspection checklist, sign-postingprotocol, and staff training scope.	