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 _____	07/13/2026

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

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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 an annual survey initiated at your facility on 07/13/26. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II residents. The census at the time of the survey was 11. 11 resident files and four employee files were reviewed. The facility received a grade of A.			
Y 0087 SS= F	**NAC 449.199** 3. A residential facility must not accept residents in excess of the number of residents specified on the license issued to the owner of the facility. Inspector Comments: Based on observations, interviews, and record review the facility failed to ensure it did not accept residents in excess of the number specified on the license. Findings include: On 07/13/26 in the morning, the facility's license documented the facility was licensed for 10 category two residents. While touring the facility a total of 11 residents were observed residing in the facility. On 07/13/26 in the morning, the owner indicated all residents were receiving care in the facility. The owner verbalized the care	Y 0087	The resident KK and SK (couple) discharged from the facility on July 25, 2026 bringing down the census at the time to 9 residents. The Administrator will ensure that the facility census does not exceed the licensed capacity of 10 residents. Before accepting any new admission, the Administrator or designee will review the current census, including residents who are temporarily hospitalized or otherwise absent but remain admitted to the facility. A centralized admission and discharge log will be maintained and updated immediately following every admission, discharge, transfer, or death.	08/13/2026

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	included medication administration and assistance with Activities of Daily Living (ADLs). The Owner explained a married couple resided in the facility and that was why the facility was over 10 residents. The Owner was unaware if a resident was receiving care, that resident counted toward the census, even if the resident was married to one of the other residents. All 11 residents in the facility had a resident file, which documented services were provided by the facility. On 07/13/26 in the morning, the Owner indicated understanding since both R7 and R8 were receiving care in the facility they counted as two separate residents which put the facility over their census. Severity: 2 Scope: 3		Only the Administrator may approve new admissions after confirming that an authorized bed is available. The census will be reviewed and documented monthly and again before every proposed admission. Staff involved in referrals and admissions will be educated regarding the facility's maximum capacity and instructed not to accept or promise placement without the Administrator's approval. Monthly compliance audits will be conducted for six months and biannually thereafter. Any discrepancy will be corrected immediately. These measures will help ensure continued compliance and prevent the deficient practice from recurring.	
Y 0930 SS= F	**NAC 449.2749** **Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.** 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized	Y 0930	The following documents were requested from the Residents' Home Health / Hospice providers, were faxed to the facility and filed in the residents' charts : R3 = Physician Assessment and 2-step TB test R6 = TB Quantiferon Test R 9 = Physician Assessment and	08/13/2026

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	use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him. (c) A statement of the resident's allergies, if any, and any special diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of		2-step TB test The ADL assessments for R3, R4, R6, R9 were completed on 7/15/2026 and filed in the patient's charts. The Administrator will implement a standardized pre-admission and resident-record checklist to ensure that all required documentation–including current TB screening results, an ADL assessment, and the Initial Physician Assessment–is obtained, reviewed for completeness, and placed in the resident's record within the time frames required by state regulations. The Administrator or designated staff member will verify and initial the checklist before each admission. A resident will not be admitted unless all documentation required before admission has been received and reviewed. Any document permitted to be completed after admission will be entered into a centralized tracking log with its required completion date and assigned staff member. The Administrator will review the tracking log weekly and conduct monthly audits of all new-	

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	NRS and the regulations adopted pursuant thereto. (f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he 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 change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i)The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the		admission records for six months, followed by biannual audits thereafter. Staff responsible for admissions and recordkeeping will receive training on documentation requirements, regulatory time frames, and the new verification process. Missing, incomplete, or expired documents will be addressed immediately, and corrective follow-up will be documented. These systematic measures will ensure continued compliance and prevent the deficient practice from recurring.	

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	administrator of the facility when the resident permanently leaves the facility. 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death. 3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau. Inspector Comments: Based on interview and record review the facility failed to ensure an initial physical was completed for 2 of 11 residents (Resident #3 and Resident #9) an Activities of Daily Living (ADL) assessments were completed for 4 of 11 residents (Resident #3, Resident #4, Resident #6 and Resident #9), and initial 2-step Tuberculosis (TB) testing was completed for Resident #3, Resident #6, and Resident #9).			

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	Findings include: Resident #3 (R3) R3 was admitted to the facility on 05/03/26 with a diagnosis of Dementia. R3's record lacked documented evidence R3 had completed an initial physical, an initial ADL assessment and an initial two-step TB test upon being admitted to the facility. Resident #4 (R4) R4 was admitted to the facility on 05/25/26 with a diagnosis of Dementia. R4's record lacked documented evidence R4 had completed an initial ADL assessment upon being admitted to the facility. Resident #6 (R6) R6 was admitted to the facility on 04/11/26 with a diagnosis of Dementia. R6's record lacked documented evidence R6 had completed an initial ADL assessment, and an initial two-TB step test upon being admitted to the facility. Resident #9 (R9) R9 was admitted to the facility on 06/25/06 with a diagnosis of Dementia. R9's record lacked documented evidence R9 had completed an initial physical, an initial ADL assessment, and an initial two-TB step test upon being admitted to the facility. On 07/13/26 in the morning, the Owner acknowledged R3 and R9's record lacked documented evidence an initial physical was completed upon admission to the facility, and R4's record lacked documented evidence initial ADL assessments were completed and also acknowledged R3, R6, and R9's record lacked documented evidence an initial ADL assessment and an initial two-TB step test were completed. Severity: 2 Scope: 3			