DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/21/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROYAL PLACE, INC	**3644 MOUNTCREST DRIVE, LAS VEGAS, NEVADA ,89121**

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated at your facility on 01/21/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was eight. The sample size was five. There was one complaint investigated. Complaint #NV00059992 with four allegations could not be substantiated. Allegation #1: A resident was verbally abused by staff and had to be moved to another facility. Allegation #2: The facility had a sewage backup with raw sewage coming out of the sinks and toilets. Allegation #3: The facility had a bad odor. Allegation #4: The facility failed to return money to a resident upon discharge. The investigation into the allegations included: Interviews were conducted with a Caregiver, the Owner and four residents. Review of five medical records including the resident of concern and five employee files. 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. There were no regulatory deficiencies identified. Please retain a copy for your records.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.