

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

PRINTED: 6/15/2026  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/14/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AEGIS LIVING LAS VEGAS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                       |                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>9100 WEST DESERT INN RD., LAS VEGAS, NEVADA ,89117</b> |                            |                                                        |  |
| (X4)<br>ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                                                        | (X5)<br>COMPLETION<br>DATE |                                                        |  |
| 0000                                                              | <p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 04/14/25, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups The census at the time of the survey was 42. The sample size was five. There was one Facility Reported Incident (FRI) investigated. The facility received a Grade of A. Substantiated without deficient practice: FRI #11186 was substantiated with no deficient practice. The investigation of FRI included: Observation of facility exit doors and alarms, facility staffing and a tour of the facility. Interviews were conducted with a Medication Technician, the Health Services Director and the Administrator. Clinical Record Review of five records, which included the resident of concern. Document Review included staffing schedules, facility training and facility policy and procedures. 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. No further action necessary. Please retain a copy for your records.</p> | 0000                                                  |                                                                                                                          |                                                                                                        |                            |                                                        |  |

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

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.