STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10333	A. BUILDING _____ B. WING _____	01/13/2026

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AEGIS LIVING LAS VEGAS	9100 WEST DESERT INN RD., 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 01/13/26. The facility is licensed for 72 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 34. Ten resident files and ten employee files were reviewed. The facility received a grade of A.			
Y 0250 SS= F	NAC 449.217 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees Fahrenheit or less. 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all	Y 0250	Plan of correction 1. We will correct the specific findings of noted Critical Violations in the walk-in cooler by removing all expired cartons of buttermilk and removing the expired whipped cream and we will correct the specific findings of expired milk in the serving kitchen by removing the expired milk. We will correct the Major Violations of food debris build up around the blade of the deli slicer and grime build up on the interior components of the ice machine by cleaning these areas immediately. We will correct the areas of grease build up on cook's line ventilation hood filters and debris on the sides of cooking equipment by cleaning them immediately. We will correct the issue of the steam tables not operating by having them repaired promptly. 2. Systematic changes and operational measures that will be deployed to ensure that these deficient practices do not recur are a.) Daily AM and PM physical	02/15/2026

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	times. 5. Pesticides and other toxic substances must not be stored in any area in which food, kitchen equipment, utensils or paper products are stored. Soaps, detergents, cleaning compounds and similar substances must not be stored in any area in which food is stored. Inspector Comments: Based on observation on 01/13/2026, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the walk-in cooler, there were five cartons of buttermilk expired on 12/20/25 and one container of whipped cream expired on 07/06/25. In a serving kitchen refrigerator, a carton of milk was expired on 01/09/26 and had an opened dated of 01/10/26. 2. Major Violations: a. The following food contact surfaces were soiled: there was food debris build-up around the blade of the deli slicer and there was grime build-up on the interior components of the ice machine. b. The following non-food contact surfaces were soiled: there was grease build-up on the cook's line ventilation hood filters and there was grease and food debris on the sides of the cooking equipment. 3. Equipment and Maintenance Violations: a. The steam table in the main kitchen was not operating. Severity: 2 Scope: 3		inspections of our main kitchen walk in and also the three neighborhood refrigerators to inspect for expirations dates and taking intentional and decisive actions to support safe practices, b.) Daily inspection check-list records will be created and deployed that address and document our attentiveness to the cleanliness of slicer, interior components of the ice machine, ventilation hood filters and sides of cooking equipment and that all equipment is fully operational. 3. The corrected actions will be monitored by the deployment of Daily checklist that address each noted area and that these documents are reviewed with signed acknowledgement daily by the Chef. 4. The persons responsible for the implementations and sustainability of the plan of correction will be the Chef and the General Manager. 5. Corrective actions & efforts will be completed by February 15, 2026 6. Document samples will be attached 7. We will identify and correct other areas having potential to be affected by same deficient practices by performing a full kitchen operations walkthrough each month.	

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Y 0991 SS= F	**NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personal required; training for employees.** (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure a door leading to the middle courtyard was equipped with a functional audible alarm. Findings include: On 01/13/2026 in the morning, a door located in the hallway near the main laundry room, was observed to be unlocked and was not equipped with a functional audible alarm. On 01/13/2026 in the morning, the maintenance director verbalized the door was left unlocked, was not alarmed, and used by residents to enter the courtyard. The maintenance director verbalized the alarm to the door needed repair and was working with a door company to schedule the repair. On 01/13/2026 in the morning, the Administrator acknowledged the door leading to the courtyard should be locked and alarmed.	Y 0991	Inspector Comments: Based on observation and interview, the facility failed to ensure a door leading to the middle courtyard was equipped with a functional audible alarm. Findings include: On 01/13/2026 in the morning, a door located in the hallway near the main laundry room, was observed to be unlocked and was not equipped with a functional audible alarm. On 01/13/2026 in the morning, the maintenance director verbalized the door was left unlocked, was not alarmed, and used by residents to enter the courtyard. The maintenance director verbalized the alarm to the door needed repair and was working with a door company to schedule the repair. On 01/13/2026 in the morning, the Administrator acknowledged the door leading to the courtyard should be locked and alarmed. Severity: 2 Scope: 3 1. We will correct the issue of the courtyard door not having functional audible alarms by ensuring our door vendor makes necessary repairs expeditiously. 2. The systematic measures and changes to be put in place to be sure the issue does not recur will be to place a battery-operated door alert motion detector as backup system until the door is fully repaired. We will also keep the backup device in place as a safety effort moving forward. 3. The corrected actions that will be taken to ensure that the deficient practice does not recur will be documented, daily walkthrough inspections of all door alarms and record keeping of same. 4. The persons responsible for ensuring the plan of correction is implemented and documentation of same is captured will be the Maintenance Director and General Manager. 5. The date that these corrective actions will be completed is February 15, 2026. 6. Any necessary supporting documents will be attached. 7.We will identify and correct other areas having potential to be affected by this same deficient practice by including all alarms doors being subject to daily walkthrough	02/15/2026

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	Severity: 2 Scope: 3		inspections and checked twice daily and documented in record.	
Y 0878 SS= D	NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician , physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician , physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse.. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription	Y 0878	the facility failed to ensure a resident received medications per the physicians' orders, and failed to ensure a resident's record had documented evidence a physician was notified after a resident had missed medications f 1. The specific findings will be addressed and corrected by Aegis staff acting with focused and deliberate intentionality and documenting who we notified and related commentary in our resident charts when a medication is not given as prescribed. 2. The measures and systemic changes that will be put in place to ensure the deficient practice does not recur will include a.) Provide an exacting and principled In-Service addressing the documentation in chart expectations, b.) Thoughtful and purpose driven routine and documented clinical community walk thru AM and PM shift by minimum two of the five community Leaders (General Manager, Health Service Director, Memory Care Director, Wellness Nurse, Asst Memory Care Director) to support our genuine commitment to this effort. 3. The corrective actions will be monitored to be sure the deficient practice does not recur by initiating and sustaining the above noted thoughtful and purpose driven routine and documented clinical community walk thru AM and PM shift by minimum two of the five community Leaders (General Manager, Health Service Director, Memory Care Director, Wellness Nurse, Asst Memory Care Director) to support our genuine commitment to this effort. 4. The titles of persons responsible for ensuring the plan of correction is implemented are the General Manager and Health Service Director. 5. The date the corrective action will be completed is February 15, 2026. 6. Documents that will be attached are: a.)	02/15/2026

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	signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident received medications per the physicians' orders, and failed to ensure a resident's record had documented evidence a physician was notified after a resident had missed medications for 1 of 9 sampled residents. (Resident #4) Findings include: Resident #4 (R4) R4 was admitted on 12/03/25 with diagnoses including delirium and dementia. A physician's order dated 01/08/26 and R4's January 2026 Medication Administration Record (MAR) documented Allopurinol 100 mg (milligram) tablet, take one tablet by mouth every day for gout/kidney stones. The initials on the MAR were circled and documented the medication was unavailable and the facility was waiting for supply at 8:00 AM on 01/12/26 and 8:00 AM on 01/13/26. There was no documented evidence R4 was administered the Allopurinol. A physician's order dated 01/08/26 and R4's		In-Service training documents, b.) Community Clinical Walkthrough Documents 7. We will identify and correct other areas having potential to be affected by same deficient practice thru intentional observations on our daily Community Clinical Walkthroughs and documenting any findings.	

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	January 2026 MAR documented Aripiprazole 2 mg tablet, take 0.5 tablet by mouth at bedtime. The initials on the MAR were circled and documented the medication was unavailable and the facility was waiting for supply at 6:00 PM on 01/12/26. There was no documented evidence R4 was administered the Aripiprazole. A physician's order dated 01/08/26 and R4's January 2026 MAR documented Labetalol HCL 200 mg tablet, take 1 tablet by mouth twice a day for hypertension. The initials on the MAR were circled and documented the medication was unavailable and the facility was waiting for supply at 8:00 AM and 8:00 PM on 01/12/26 and 8:00 AM on 01/13/26. There was no documented evidence R4 was administered the Labetalol. There was no documented evidence R4's physician was notified after the missed doses of medications. On 01/13/26 in the morning, the Medication Technician (Med Tech) acknowledged R4's Allopurinol, Aripiprazole and Labetalol were not administered per the physician's order because they were not onsite. The Med Tech confirmed the facility had no documented evidence R4's physician was notified after the missed doses. Severity: 2 Scope: 1			
Y 0874 SS= A	NAC 449.2742 **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 2. Within 72 hours after the	Y 0874	1. We will correct this specific finding by establishing the General Manager e-mail address as a recipient of these reports. 2. The measures and systematic changes that will be put in place to ensure the deficient practice does not recur will be to add the General Manager as a recipient of the email notifications and reports so the General Manager may engage the expected practices.	02/15/2026

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	administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. <u>The report must be reviewed and initialed by the administrator.</u> Inspector Comments: Based on record review and interview, the facility failed to ensure the Administrator reviewed and initialed six-month medication reviews for 8 of 10 sampled residents (Resident #1, Resident #2, Resident #3, Resident #5, Resident #7, Resident #8, Resident #9, and Resident #10). Findings include: Resident #1 (R1) R1 was admitted on 07/22/22 with diagnoses including Parkinson's Disease and dementia. R1's 01/23/25, 08/07/25, and 11/21/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #2 (R2) R2 was admitted on 09/06/23 with a diagnosis of dementia. R2's 08/07/25 and 11/21/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #3 (R3) R3 was admitted on 02/06/24 with diagnoses including altered mental status and hypertension. R3's 08/07/25 and 11/21/25 Medication Reviews lacked documented evidence of the Administrator's review and initials.		3.The corrective action will be monitored so as to ensure deficiencies do not recur by having the General Manager and Health Services Director add this task as a review point at weekly 1:1 meetings and also will collaborate together upon receipt of notifying emails and reply simultaneously. 4. The titles of the persons responsible for ensuring the plan of correction is implemented is the General Manager and Health Services Director. 5. The date this corrective action will be completed is February 15, 2026. 6. Any needed attachments will be uploaded. 7. We will identify and correct other areas having a potential to be affected by same deficient practice by reviewing reporting expectations and our response to same at our weekly 1:1 meetings.	

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	Resident #5 (R5) R5 was admitted on 04/09/25 with a diagnosis of dementia. R5's 08/07/25 and 11/21/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #7 (R7) R7 was admitted on 03/09/23 with diagnoses including hypothyroidism and unspecified dementia with behavioral disturbance. R7's 03/10/25, 08/07/25, and 11/21/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #8 (R8) R8 was admitted on 04/21/23 with diagnoses including vascular dementia and Diabetes Mellitus Type 2. R8's 01/23/25, 08/07/25, and 11/21/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #9 (R9) R9 was admitted on 06/17/25 with diagnoses including dementia, anxiety, and Benign Prostatic Hyperplasia. R9's 08/07/25 and 11/21/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #10 (R10) R10 was admitted on 03/31/25 with a diagnosis of dementia. R10's 08/07/25 and 11/21/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. On 01/13/26 in the afternoon, the			

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	Administrator acknowledged the missing Administrator initials on the Medication Reviews conducted in 2025 for R1, R2, R3, R5, R7, R8, R9, and R10. Severity: 1 Scope: 1			