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 _____	**09/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS SENIOR LIVING	**6650 W FLAMINGO RD, LAS VEGAS, NEVADA ,89103**

(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: The Statement of Deficiencies was generated as a result of a complaint investigation survey conducted in your facility on 09/16/25, in accordance with Nevada Administrative Code, Chapter 449, and Nevada Revised Statutes Chapter 449-Residential Facility for Groups. The census was 105. The sample size was two. The facility received a grade of A. Two complaints were investigated. Substantiated Without Deficient Practice: 1. Complaint #NV00074344 was substantiated without deficient practice. 2. Complaint #NV00074746 was substantiated without deficient practice. The investigation into the complaints included: Observations of residents, including residents of concern. Interviews with residents, including the residents of concern, a Caregiver, a Medication Technician, the Wellness Director and the Administrator. Clinical Record Review of residents, including the residents of concern and an employee. Document review of facility Policies and Procedures, Incident Reports. 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 law. No regulatory deficiencies were identified. No further action required. Save 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.