

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/05/2022
NAME OF PROVIDER OR SUPPLIER MAYHILL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3855 MAYHILL AVE, LAS VEGAS, NEVADA ,89121	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on 04/05/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, with an endorsement for Alzheimer's disease and individuals with intellectual disabilities, Category II residents. The census at the time of the survey was six. The sample size was six. The facility received a grade of A. One complaint was investigated. Complaint# NV00066010 with two allegations was unsubstantiated. Allegation #1-The facility failed to provide an adequate size bed and adequate size room for a resident was unsubstantiated based on direct measurement of all residents bed and room sizes which met regulatory requirements and interviews with six residents who indicated their room and bed were an adequate size for their needs. Allegation #2- The facility was unclean, especially the kitchen area, was unsubstantiated based on observation of the facility as a whole and the kitchen area which all appeared clean and free of foul odors and interviews with six residents, three Caregivers and the facility Administrator who indicated the whole facility, as well as all resident rooms, were cleaned (trash removed, swept, vacuumed, mopped and dusted) on a daily basis along with the kitchen (all pots, pans, dishes, silverware, cups, used appliances and stove) being thoroughly cleaned after each meal. 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			

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.

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	identified. No further action is necessary. Please retain a copy for your records.						