

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>02/21/2023</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LEGACY HOUSE OF CENTENNIAL HILLS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                       |                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>6310 N. DURANGO DRIVE, LAS VEGAS, NEVADA ,89149</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 conducted at your facility on 02/21/23 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 136 Residential Facility for Group beds for elderly or disabled persons and/or persons with Alzheimer's disease and/or persons with chronic illness, Category II Residents. The census at the time of the survey was 132. The sample size was five. The facility received a grade of A. One complaint was investigated. Complaint #NV00067583 could not be substantiated. No regulatory deficiencies could be identified. The investigation into allegations included: Observations of residents in common areas, who were awake and participating in activities. No residents were observed sleeping in common areas. Interviews with a Memory Care Coordinator, a Resident Care Coordinator, a Caregiver and five residents. Record review of four current residents and one discharged resident, including the resident of concern's file, physical exams, activities of daily living, hospital records and incident reports for the previous four months. Document review including facility incident reports and fall response 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.