

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 09/24/2024	
NAME OF PROVIDER OR SUPPLIER VILLA COURT ASSISTED LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 3985 SOUTH PEARL STREET, LAS VEGAS, NEVADA ,89121-7205			
(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: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 09/24/24, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facility for Groups. The census at the time of the survey was 61. The sample size was five. Five resident files and five employee files were reviewed. The facility received a grade of A. There were three complaints investigated. Substantiated without deficient practice: 1. Complaint #NV00071648 was substantiated with no deficient practice. 2. Complaint # NV00072078 was substantiated with no deficient practice. Unsubstantiated: 3. Complaint #NV00072000 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaints included: Observation of resident and caregiver interaction, grooming and physical appearance of residents, cleanliness of the facility. Interviews were conducted with residents, caregiver staff, medication technician, Wellness Director, the Maintenance Director, and the Administrator. Clinical Record Review of five records, which included the resident of concern. Document review of the Medication Administration Record and employee training and certifications. There were no regulatory deficiencies identified. No further action is necessary. Please retain a copy for your records.	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.