

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9830	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2025
NAME OF PROVIDER OR SUPPLIER HERITAGE SPRINGS ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 8720 W FLAMINGO RD, LAS VEGAS, NEVADA ,89147		
(X4) ID PREFIX TAG RFG 0000- No Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. The RFG was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 11/06/25, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facility for Groups. The census at the time of the survey was 77. The sample size was three. Three resident files were reviewed. The facility received a grade of A. There was one complaint investigated. Unsubstantiated 1. Complaint #12255 could not be substantiated. No regulatory deficiencies could be identified.	ID PREFIX TAG RFG 0000- No Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name:
REPRESENTATIVE'S SIGNATURE

Title:

Date:

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	The investigation of the complaint included: Observations interactions between staff and residents, residents attending activities, residents attending dining in dining room and no resident with wounds or injuries. Interviews were conducted with residents, caregiver staff, medication technician, a hospice nurse, Life Enrichment representatives and the memory care director. Clinical Record Review of three records, including the resident of concern. Document review included facility policies, menus and activity calendar. 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.			