

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 07/27/2023	
NAME OF PROVIDER OR SUPPLIER THE QUAIL HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3695 E QUAIL AVE, LAS VEGAS, NEVADA ,89120			
(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 an annual State Licensure survey initiated at your facility on 07/26/23 and completed on 07/27/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Requirements for Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons, assisted living services, and/or persons with chronic illness, and/or persons with mental illness and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was ten. The sample size was four residents and ten employees. The facility received a grade of A. There was one complaint investigated: 1. Complaint #NV00068785 could not be verified. The investigation into the complaint included: Interviews with the Administrator, the Assistant Administrator, a Manager, two Caregivers, five residents, and two family members of residents. Clinical record review of one resident (the Resident of Concern). Document review of incident reporting, resident rights, and the facility's abuse policy. 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 investigations, 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 is necessary. Please retain this Statement 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.