

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9911	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/13/2024	
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 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey completed in your facility on 11/13/24, in accordance with Nevada Administrative Code, Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly or disabled persons, and/or persons with Alzheimer's disease, and/or persons with mental illness and assisted living services Category II. The census at the time of the survey was ten. Ten resident records and four employee records were reviewed. The facility received a grade of A. 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 laws. There were no regulatory deficiencies identified:	ID PREFIX TAG 0000	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 REPRESENTATIVE'S SIGNATURE	Name:	Title:	Date:
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