DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
			02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS SENIOR LIVING	**6650 W FLAMINGO RD, LAS VEGAS, NEVADA ,89103**

(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 bed increase and complaint investigation completed in your facility on 02/10/25, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The facility is licensed for 100 Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and provides assisted living services, Category II residents. The facility has applied for a bed increase and was approved to add 25 group beds which provide services for elderly and disabled persons and/or persons with mental illness, for a total of 125 Category-II beds bringing the total number of beds to 125. The census at the time of the survey was 86. The sample size was one. There was one complaint investigated. Unsubstantiated: Complaint #NV00073044 could not be substantiated. The investigation of Complaint included: Observation of the telephone system in the facility. Interviews were conducted with residents, the Concierge, the Wellness Director and the Administrator. Record Review of one record, the resident of interest. 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. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy for your records.	0000		

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