

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER HENDERSON SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2690 CELEBRATE CT, HENDERSON, NEVADA ,89074		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of the State Licensure Initial survey completed in your facility on 04/18/24, in accordance with Nevada Administrative Code, Chapter 449, Requirements for Residential Facilities for Groups. The facility is requesting licensure for 10 Residential Facility for Group beds with an endorsement for Alzheimer's disease, Category II residents. The census at the time of the survey was zero. One sample resident file was reviewed and two employee files were reviewed. 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. No action is required. Please retain this Statement for your records.			

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: Title: Date:
REPRESENTATIVE'S SIGNATURE