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	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**04/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON SENIOR LIVING	**2690 CELEBRATE CT, HENDERSON, NEVADA ,89074**

(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 and complaint investigation at your facility on 04/16/25 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 10. Ten resident files, one discharged resident, and four employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Unsubstantiated: 1. Complaint #NV00073693 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaint included: Observation of staff to resident treatment, medication storage, resident's overly sedated, physical appearance, and a tour of the facility. Interviews were conducted with residents, Caregiver, and the Manager. Record Review of eleven resident records, which included the resident of concern. Document Review included incident reports, Medication Administration Record, and policies and procedures. 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. The following regulatory deficiencies were identified.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CRISTINA LAZAR Title: Facility Director Date: 04/29/2025

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.

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0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure a door leading to the outside was equipped with an audible alarm. Findings include: On 04/16/25 at 8:45 AM, the back door alarm leading to the outside was turned off. On 04/16/25 at 8:45 AM, the Caregiver indicated the back door alarm was turned off due to resident complaints and acknowledged the alarm should have remained on to alert staff. Severity: 2 Scope: 3	0991	1. Facility director turn back on the alarm. Facility Director, had a meeting with the staff after the survey and explained to them the importance of alarms to stay on at all times. Under no circumstances they will be turning off the alarms. 2. Facility Manager makes daily visits to the facility and she will check and ensure that the alarm is on. 3.The Facility Director and Administrator will check if alarm is on during their weekly visit to the facility. 4. The administrator will monitor and ensure the alarm is on at all times and this will not happen again. 5. This has been corrected on 4/25/2025	04/28/2025

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0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were not accessible to residents. Findings include: On 04/16/25 at 8:50 AM, the lock on the garage door was reversed with the locking mechanism on the garage side of the door making toxic substances stored in the garage assessible to residents. Toxic substances included unsecured multipurpose cleaner, air freshener, perineal cleanser, and stainless steel cleaner. On 04/16/25 at 8:50 AM, the Caregiver acknowledged the toxic substances were unsecured and should have been locked. Severity: 2 Scope: 3	0999	1. The facility has switched the lock on the door between house and garage. Door is locked at all times now. 2. Facility manager had a meeting with the staff and gave them a key to that door. Staff needs to use a key to open the door in order to go to the garage. 3. Manager will check during her daily visits to the facility to ensure door is locked between the house and garage and residents do not have access to the garage. 4. Facility Director and Administrator will check as well during their weekly visits to the facility to ensure that door between the house and garage is locked. 5. This has been corrected on 4/25/2025	04/28/2025