Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4880	A. BUILDING _____ B. WING _____	01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF HENDERSON	1555 WEST HORIZON RIDGE PARKWAY, HENDERSON, NEVADA ,89012

(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 and infection control survey conducted at your facility on 01/19/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 105 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease and provides assisted living services, Category II residents. The census at the time of the survey was 63. Fifteen resident and six employee files were reviewed. The facility received a grade of A. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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. The following regulatory deficiencies were identified.	0000		

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: TRACI HOLLINGSWORTH	Title: Executive Director	Date: 02/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4880	A. BUILDING _____ B. WING _____	01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF HENDERSON	1555 WEST HORIZON RIDGE PARKWAY, HENDERSON, NEVADA ,89012

(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
0255 SS= E	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 01/18/2022, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the serving kitchen, on the second floor, the reach-in refrigerator containing milk and juice was at 45.6 degrees Fahrenheit (F). Severity: 2 Scope: 2	0255	1. With respect to the specific resident/situation cited: All food and drink items in the second-floor refrigerator were immediately discarded. 2.With respect to how the facility will identify residents/situations with the potential for the identified concerns: A new thermometer was placed in this refrigerator. A temperature log for this refrigerator was initiated and temperatures will be taken and recorded daily. If temperatures ar out of range, food and drink will be discarded and the maintenance coordinator will be notified to inspect the refrigerator and take corrective action. 3. With respect to what systemic measures have been put into place to address the stated concern: Additional thermometers have been purchased. Thermometers have been placed in each common area refrigerator in the community. Kitchen and dining staff will check refrigerator temperatures daily in all common area refrigerators to confirm temperatures are 40 degrees or lower. The team has been educated about actions to take if temperatures are above 40 degrees and to report the issue to maintenance. 4. With respect to how the plan of correction will be monitored: During the weekly leadership meeting, the Executive Director and Dining Services Coordinator will confirm that temperatures are logged daily on all common area refrigerators. The Executive Director will be responsible for ongoing compliance to this plan.	02/04/2022
0878	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-	0878	1. With respect to the specific resident/situation cited: A discontinue order was obtained from the primary care provider for this resident's medication and record and placed in the resident's file. 2. Corrective Action for Other Residents: A medication cart/MAR audit will be completed on each medication cart in the community. Any discrepancies between orders and medications will be corrected by notifying the primary care provider and obtaining necessary orders.	02/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4880	A. BUILDING _____ B. WING _____	01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF HENDERSON	1555 WEST HORIZON RIDGE PARKWAY, HENDERSON, NEVADA ,89012

(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
	the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, record review and interview, the facility failed to obtain discontinue orders for medications for 1 of 15 residents (Resident #14). Findings include: Resident #14 (R14) R14 was admitted on 02/29/20, with a diagnosis of dementia. R14's Medication Administration Record (MAR) documented the medications Simethicone 125 milligrams (mg) take one tablet by mouth every six hours as needed (PRN) and Senna-docusate sodium 8.6 mg-50 mg take one tablet by mouth every 24 hours PRN. On 01/18/22 in the morning, neither medications could be located at the facility. The Manager verbalized both medications were discontinued in February 2021 and was unable to provide a discontinued order. The Manager acknowledged a discontinued order should have been obtained. Severity: 2 Scope: 1		3. Systemic Correction to Prevent Recurrence: Medication Care Managers will perform weekly medication cart/MAR audits on community medication carts. Licensed nurse will perform a full audit of each medication cart once per month. Any discrepancies will be reported to the Resident Care Director and corrected. 4. Monitoring Plan: The Resident Care Director or designee will bring weekly and monthly medication cart audits to the weekly interdisciplinary meeting for review. The Executive Director will be responsible for ongoing compliance to this plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4880	A. BUILDING _____ B. WING _____	**01/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF HENDERSON	**1555 WEST HORIZON RIDGE PARKWAY, HENDERSON, NEVADA ,89012**

(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