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 _____	**05/24/2022**

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 a complaint investigation conducted at your facility on 05/24/22, 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 79. The facility received a grade of A. One complaint was investigated. Complaint #NV00066174 with four allegations was substantiated without deficiencies. Allegation #1: A family member was not permitted to visit a resident was substantiated without deficiencies based on review of a police incident report from April 2022 which indicated the family member was trespassed by police per management because the family member was causing a disturbance. Review of an incident report from a local Skilled Nursing Facility from March 15, 2022 indicating the family member had been trespassed from the facility for causing a disturbance. Review of documentation showing the resident of concern has a Power of Attorney (POA) in place. Interview with the Resident who explained they want their POA to intervene on their behalf and do not feel the facility is preventing anyone the Resident wants to see from visiting. Interview with the Resident's POA who explained the family member is not allowed to visit due to the family member caused multiple disturbances in the past. Interview with the Reminiscence Coordinator and the Executive Director who confirmed the family member caused a disturbance, was trespassed in April 2022 and returned in April 2022 in violation of the trespass order which resulted in the family member's arrest. Allegation #2: A resident did not	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.

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	receive oxygen as prescribed was not substantiated based on review of discontinue order from April 2022 from the resident of concern's physician. Interview with Reminiscence Coordinator who explained the doctor had issued a discontinue order in April 2022. Allegation #3: The facility staff were hiding a resident's walker in the back of a resident's closet could not be substantiated based on observations of the resident of concern seated on their walker upon arrival at the facility. Interview with the Resident who explained their walker was always easily accessible at all times. Allegation #4: A resident was left in bed and not groomed by facility staff could not be substantiated based on observations the resident of concern was observed dressed and groomed and in their walker during an unannounced visit at 8:45 AM. Interview with the Resident who explained the staff are always helpful and helped the Resident out of bed when they needed assistance. The investigation into the allegation included: Observations of residents and employee interactions with residents in the hallways, the dining room, and activity area. Interviews with resident of concern, resident of concern's POA, the Reminiscence Coordinator, and the Executive Director. Documentation review of one resident file including diagnoses and medication orders, police department incident reports from April 2022, POA paperwork, and an incident report from a local Skilled Nursing Facility. 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 further action necessary. Please retain a copy for your records.			