

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 09/25/2024	
NAME OF PROVIDER OR SUPPLIER SUNRISE OF HENDERSON				STREET ADDRESS, CITY, STATE, ZIP CODE 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 completed in your facility on 09/25/24, in accordance with Residential Facility for Groups. The census at the time of the survey was 93. The sample size was five. There was one complaint investigated. The facility received a grade of A. Substantiated without deficient Practice: 1. Complaint #NV00072306 was substantiated with no deficient practice. The investigation of the complaint included: Observation of the memory care unit, residents on isolation precautions, availability of and staff wearing personal protective equipment (PPE), and appropriate signage. Interviews were conducted with a nurse practitioner, Caregiver, Medication Technician, Housekeeper, Memory Care Coordinator, and the Wellness Director. Record Review of five records, which included the residents of concern. Document review of 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. There were no regulatory deficiencies identified. No further action necessary. Please retain a copy for your records.	0000					

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

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.