

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4880	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2026
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 RFG 0000- No Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. The RFG was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey initiated at your facility on 03/24/26. The facility is licensed for 105 Residential Facility for Group beds for elderly and disabled persons,45 Alzheimer's disease, Category II residents and 60 Category II non Alzheimer's residents. The census at the time of the survey was 82. Twenty resident files and eight employee files were reviewed. The facility received a grade of A.	ID PREFIX TAG RFG 0000- No Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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:
REPRESENTATIVE'S SIGNATURE

Title:

Date:

STATE FORM Event ID: Facility ID: Page 2 of 2