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
	12307	A. BUILDING _____ B. WING _____	08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR SENIOR LIVING AT WESTGATE	2910 W HORIZON RIDGE PKWY, HENDERSON, NEVADA ,89052-3986

(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
RFG 0000- No Deficiencies	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, 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 facility 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 a complaint investigation completed at your facility on 08/05/26 in accordance with Nevada Administrative Code, chapter 449, and Nevada revised statues chapter 449 Residential Facility for Groups (RFG), medical facilities and other related entities. The facility is licensed for 116 Residential Facility for persons with elderly and disabled and/or persons with Assisted Living Services, Category II. The census at the time of the survey was 87. The sample size was 20. Twenty resident files were reviewed. The facility received a grade of A.	RFG 0000- No Deficiencies		

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: Title: Date:

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	There was one complaint investigated. Substantiated without deficiencies Complaint #NV00014139 was substantiated without deficiencies. The investigation of the complaint included: Observations of removal of cameras in resident rooms who did not consent and the computer system for the cameras. Interviews with residents, caregivers, a Medication Technician, Administrator and COO. Record review of twenty resident files. Document review of the signed agreement for cameras, updated Policy for cameras and updated signed agreement form for resident who had opted out of using the system.			