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 _____	**08/01/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANA LIVING, AN AFFILIATE OF WC HEALTH	**5975 W. TWAIN AVENUE, LAS VEGAS, NEVADA ,89103**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey, complaint investigation and voluntary regrading survey completed at your facility on 08/01/24 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 102 Residential Facility for Group beds for elderly and disabled persons, assisted living services and/or mental illness, and 20 persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 86. Twenty resident files and ten employee files were reviewed. The facility received a grade of B. There was one complaint investigated. Unsubstantiated: Complaint #NV00071717 could not be substantiated. No regulatory deficiencies could be identified. The investigation of complaint included: Observation of residents and staff interactions. An interview was conducted with the Executive Director. Record Review of residents of concern. Document Review of facility incident reports. 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. The following regulatory deficiencies were identified:	0000		
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the exterior and interior of the building was	0178	1. We have a maintenance log for repairs and corrections. All of the following items are placed on the repair log. A walk through is done daily and items that are need of repair are placed on this log. We will correct these items by adding them to our daily maintenance log which was completed that day it was brought to our attention. COMPLETION OF ITEM: This will be signed by the team member doing the repair once complete. You can see this in	08/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: NICHOLE SCHMAL Title: Executive Director Date: 09/11/2024

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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	clean and free of hazards. Findings include: On 08/01/24 in the morning, two tree stumps were located in the yard of the memory care unit. The yard was an enclosed area that was used by residents and could be a tripping hazard. On 08/01/24 in the morning, large amounts of pigeon feces were observed in the courtyard and on a balcony outside of the activity room. On 08/01/24 in the morning, maintenance personnel confirmed there were two tree stumps that needed to be removed in the yard of the memory care unit and large amounts of pigeon feces needed to be cleaned up in the courtyard and on the activity room patio. On 08/01/24 in the morning, in the centrally located courtyard located outside the facility there was a decorative water fountain. At the base of the water fountain, there was a duplex outlet, not tamper-proof which was installed with a protective plastic box cover that was missing the hinged cover. The purpose of the hinged cover was to protect the outlet from possible water or weather damage and the residents from tampering with the exposed outlets. On 08/01/24 in the morning, located on the exterior of the building within the centrally located courtyard was an open electrical box which was part of the facility's irrigation system that had exposed electrical wires not fitted with the appropriate cap covers. On 08/01/24 in the morning, on the second floor located by resident room #218 was a rest room without soap or paper towels. On 08/01/24 in the morning, on the first floor located by resident room #118 was a rest room (#150) that had the following maintenance/housekeeping issues: a strong urine odor baseboard behind the toilet was loose and coming off the wall around the base of the toilet was an unknown black substance On 08/01/24 in the morning, a sprinkler head in resident room #220's closet was observed with masking tape. The maintenance staff acknowledged the masking tape as the discovery was made		the form I have attached to this plan of correction. ***PLEASE SEE ATTACHED FORM ON PLAN OF CORRECTION**** - STUMPS HAVE BEEN REMOVED - PEGION FECES ON BALCONY CLEANED - OUTLET BY FOUNTAIN REPAIRED - IRRIGATION BOX REPAIRED - SOAP AND TOWELS ADDED AND CLEANED DAILY - ROOM 118 CLEANED WEEKLY - MASKING TAPE REMOVED AND FIRE NOTIFIED OF DUST THEY INFORMED US NOT TO TOUCH THEM - ESCUTCHEN RING REPORTED TO FIRE THEY ARE HANDLING THAT - FLOORING REPAIRED IN ROOMS AND SEALED 2. This measure was taken as so as it was brought to our attention and added to the log that day for repair of item. Daily these items are logged and repaired and signed for by the team member repairing them. One can see the signature at the bottom of each individual repair and date repaired. 3. This will be monitored by observing the repair and documenting the day it was repaired and signed on the date it was repaired. 4. The Maintenance Director will repair the issue that is brought to our attention on that day or within 24 hours and document the issue repaired by signing the repair. If unable to repair at that time they will note this and place a date on which part was ordered and will be expected. 5. August 1, 2024 this was completed and signed by maintenance. 6. See the maintenance repair log attached with signature of whom completed the task. 7. Daily we walk through and document all repairs in the facility for maintenance to repair. We have many repairs throughout the day that staff or residents inform management about. Residents are encourage to report repair to maintenance so no other maintenance issues occur.	

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	and was not aware the closets had sprinkler heads. On 08/01/24 in the morning, a sprinkler head in resident room #230 had an escutcheon ring not properly seated against the ceiling and another sprinkler head with an unknown white substance on the deflector. On 08/01/24 in the morning, the flooring was lifting and not secured as expected in the center of the second floor activity room which could be a trip hazard. On 08/01/24 in the morning, The maintenance staff acknowledged the findings. Severity: 2 Scope: 3			
0870 SS= E	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on record review and interview, the facility failed to ensure a medication regimen review was completed every six months for 5 of 20 residents (Resident #1, #4, #7, #13, and #17). Findings include: Resident #1 (R1) R1 was admitted on 07/26/21, with diagnoses	0870	1. We will correct this finding by having a schedule med review on September 1 and March 1 of every year. This medication review will be performed by our contracted Pharmacist bi-annually. 2. This new bi-annually medication review by the contracted Pharmacist measure will start September 1, 2024 and occur every 6 months for the remainder of the license. 3. This corrective action will be monitored and executed by the Executive Director on the days stated. 4. The Executive Director will send out the medication review to the contracted Pharmacist 5. This corrective action will occur on September 1, 2024 and will occur bi-annually. 6. Please see attached document of the medication review sample 7. We will complete a current medication review for each resident residing at Sana Living to ensure that no resident is missing a bi-annually mediation review.	09/01/2024

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	including hypertension and arthritis. R1's file documented a medication review completed on 06/26/23, 04/14/24 and 04/04/24, which was four months late according to the every six months requirement. Resident #4 (R4) R4 was admitted on 05/26/22, with a diagnosis of hypertension. R4's file documented a medication review completed on 12/11/23 and 08/01/24, which was two months late according to the every six months requirement. Resident #7 (R7) R7 was admitted on 07/02/22, with diagnoses including anxiety and heart failure. R7's file documented a medication review completed on 11/29/23 and 08/01/24, which was a month late according to the every six months requirement. Resident #17 (R17) R17 was admitted on 09/22/22, with a diagnosis of Anxiety Disorder, Diabetes Type II, Heart Failure. R17's file review revealed a documented medication review completed on 04/04/24 but lacked documented evidence of a completed medication review for the year 2023. The facility did not provide documented evidence of the required six month medication review prior to the end of survey for R17. Resident #13 (R13) R13 was admitted on 04/03/23 with diagnoses including alcoholism and gastroesophageal reflux disease. R13's file contained medication reviews dated 06/25/23, 04/04/24, and 04/12/24. R13's file lacked documented evidence of a medication review completed in December 2023, per the every six months requirement. On 08/01/24 in the afternoon, the Executive Director was unable to produce six month medication reviews for R1, R4, R7, R13, and R17, per the requirement. Severity: 2 Scope: 2			
0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has	0885	1. We corrected this finding by printing proof of discontinue and destruction of medication for this survey for the two residents. 2. The measure taken was printing the proof and attaching it to this survey for the surveyor to see the complete discontinue	08/01/2024

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	been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure medications were destroyed for 2 of 20 Residents (Resident #4 and #7). Findings include: Resident #4 (R4) R4 was admitted on 05/26/22, with a diagnosis of hypertension. On 08/01/24 at 2:25 PM, the medication cart contained Tussin DM Liquid 10-200/5 (10 milliliters - Oral), take 10 milliliters by mouth every 6 hours as needed for cough. The Tussin DM Liquid container read an expiration date of 04/24. A Physician's Order dated 08/01/24 documented to discontinue the Tussin DM. On 08/01/24 in the afternoon, R4 verbalized they could not remember the last time they used the Tussin DM. Resident #7 (R7) R7 was admitted on 07/02/22, with diagnoses including anxiety and heart failure. On 08/01/24 at 1:19 PM, the medication cart contained Albuterol Sulfate (2.5 milligrams/3 milliliters) 0.083% nebulizer, inhale 1 vial via nebulizer every 6 hours as needed for shortness of breath. The Albuterol package read an expiration date of 05/19/24. A Physician's Order dated 08/01/24 documented to discontinue the Albuterol. On 08/01/24 in the afternoon, R7 was unable to recall needing the medication. On 08/01/24 in the afternoon, the Medication Technician (Med Tech) acknowledged the medications were expired and should have been destroyed. Severity: 2 Scope: 1		and destruction of these medications with documentation. 3. The corrective action was monitored by the Executive Director and Resident Care Coordinator. 4. The Resident Care Coordinator will monitor all Discontinue orders and destroy medication in the system. 5. This was complete on August 1, 2024 6. I have attached the proof of destruction for viewing. 7. All medication will are documented by Intake, destroyed and logged in the system and can be printed for viewing anytime. This will enable the surveyor to see that the medication was D/C and destroyed by appropriate means and documented for viewing.	

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0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure resident medications were secured. Findings include: On 08/01/24 at 8:58 AM a large black plastic tote with a yellow lid labeled, "Returned Medications," was observed unsecured in the hallway that led into the facility's kitchen. The tote contained over 10 bubble packages of various medications. On 08/01/24 at 8:59 AM a Medication Technician (Med Tech) acknowledged the tote of unsecured medications and verbalized that medications should be locked up at all times. Severity: 2 Scope: 3	0920	1. We corrected this finding by moving the box to a locked area for pick up by pharmacy. This locked area is called the Medication Room. 2. The measure taken was moving the box to a locked area for pick up. 3. This will be monitored by the Resident Care Coordinator. 4. The Resident Care Coordinator will monitor the box keeping it the locked Medication Room. 5. This was corrected August 1, 2024 6. See attached picture of box in Medication room on the floor in a black box under the desk waiting for pharmacy to disposed of the expired medications. 7. We will keep all medications in locked room or locked cart ensuring this does not happen again.	08/01/2024
1840 SS= F	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized	1840	1. We corrected this finding by conducting at training for all staff on the computer. Each employee will login on the computer and send the certificate to the Resident Care Coordinator to file in their binder. Every new employee and in August this	08/08/2024

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	organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the facility failed to ensure 6 of 10 sampled employees (Employees #2, #3, #4, #7, #9, an #10) obtained the required infection control training. Findings include: Employee #2 (E2) E2 was hired on 02/17/18 as a Caregiver. E2's employee file lacked documented evidence of training concerning the control and prevention of infections from the approved nationally recognized organizations. Employee #3 (E3) E3 was hired on 09/10/19 as a Caregiver. E3's employee file lacked documented evidence of training concerning the control and prevention of infections from the approved nationally recognized organizations. Employee #4 (E4) E4 was hired on 09/20/23 as a Medication Technician. E4's employee file lacked documented evidence of training concerning the control and prevention of infections from the approved nationally recognized organizations. Employee #7 (E7) E7 was hired on 02/14/23 as a Caregiver. E7's employee file lacked documented evidence of training concerning the control and prevention of infections from the approved nationally		new program will be completed. August is Infection Control training month and will be added to the training schedule. All staff will be required to complete Infection Control training that will commence in the month of August. 2. The systematic change is every August we will conduct a online training for all staff to complete. All new hires will have infection control training upon orientation. 3. These corrective action will be monitored in August yearly for all current staff and upon hire in orientation for all new staff. 4. The Manager of Human Resources will create the email that will be sent out for all staff to complete Infection Control Training. 5. This training occurred on August 8, 2024 and will be completed annually 6. I have attached all the employee Infection Control Training for Sana Living 7. We have a monthly training program to stay compliant for trainings. This will ensure that monthly staff is being trained appropriately.	

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	recognized organizations. Employee #9 (E9) E9 was hired on 02/19/23 as a Caregiver. E9's employee file lacked documented evidence of training concerning the control and prevention of infections from the approved nationally recognized organizations. Employee #10 (E10) E10 was hired on 06/25/19 as a Medication Technician. E10's employee file lacked documented evidence of training concerning the control and prevention of infections from the approved nationally recognized organizations. On 08/01/24 in the afternoon, the Executive Director acknowledged E2, E3, E4, E7, E9, and E10 did not receive the required infection control training. Severity: 2 Scope: 3			