

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 03/20/2025
NAME OF PROVIDER OR SUPPLIER SANA LIVING, AN AFFILIATE OF WC HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5975 W. TWAIN AVENUE, LAS VEGAS, NEVADA ,89103	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 03/20/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 94. The sample size was five. The facility received a grade of A. There were four complaints investigated. Substantiated: 1. Complaint #NV00073429 was substantiated. (See TAG Y0393). Unsubstantiated: 2. Complaint #NV00073424 could not be substantiated. No regulatory deficiencies could be identified. 3. Complaint #NV00073409 could not be substantiated. No regulatory deficiencies could be identified. 4. Complaint #NV00073249 could not be substantiated. No regulatory deficiencies could be identified. The investigation of complaints included: Observation of grooming and physical appearance for residents, no photos being taken of residents, no resident with bruising or apparent injuries, odors, meal observation and call bells. Interviews were conducted with residents, Caregivers, a Medication Technician and the Wellness Director. Record Review of five records, which included the residents of concern. Document Review included facility policy and procedures on pharmacy services, payment authorizations, accounting authorizations and call bell response, menu and 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 deficiency was identified:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: NICHOLE R SCHMAL Title: Executive Director
REPRESENTATIVE'S SIGNATURE

Date: 04/15/2025

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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0393 SS= D	Safety Requirements - NAC 449.226 Safety requirements for residents with restricted mobility or poor eyesight; water hazards; auditory systems for bathrooms and bedrooms; access by vehicles. (NRS 449.0302) 4. In a residential facility with more than 10 residents: (a) Each resident must be provided with, or the bedroom and bathroom of each resident must be equipped with, an auditory system that is monitored by a member of the staff of the facility. (b) An auditory system must be available for use in the bathroom of each resident of the facility if the facility was issued its initial license on or after January 14, 1997, so that a resident needing assistance can alert a member of the staff of the facility of that fact from the toilet and the shower. (c) A bathroom that is located in a common area of the facility must be equipped with an auditory system that is monitored by a member of the staff of the facility. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure 1 of 4 sampled residents had a call bell (Resident #4). Resident #4 (R4) R4 was admitted on 09/19/24, with a diagnosis of Parkinson's disease. On 03/20/25 at 10:36 AM, R4 was observed lying in bed and reported R4 did not have an assessable call bell or pendant to request assistance. R4 explained they would yell for help until someone responded and indicated they were unable to get up independently. On 03/20/25 at 11:00 AM, two Caregivers confirmed R4 did not have an assessable call bell and could not reach the pull chord in the bathroom. On 03/20/25 at 11:45 AM, the Wellness Director indicated R4 should have a call bell and was unaware R4 did not have one. The (undated) Call Light System Policy documented residents must wear the pendant at all times for safety purposes. Severity: 2 Scope: 1 Complaint #NV00073424	0393	1. We corrected this finding by having all the auditory system installed in all of the bedrooms. 2. We have installed the auditory emergency call pull cord as a permanent fixture so this deficiency will not occur. 3. This will be monitored monthly with maintenance testing the pull cords monthly. 4. The Executive Director ordered all items and maintenance installed and will test system monthly. 5. This was corrected on March 24 2025 6. Attached is the purchase and picture of install. 7. All of the other rooms have auditory system installed so no deficient practice will occur for any other individual.	03/24/2025