

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2026
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 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: The Statement of Deficiencies was generated as a result of a complaint investigation survey conducted in your facility on 05/07/26, in accordance with Nevada Administrative Code, Chapter 449, and Nevada Revised Statutes Chapter 449 - Residential Facility for Groups. The census was 88. The sample size was five. The facility received a grade of A. One complaint was investigated. <u>Unsubstantiated:</u> 1. Complaint #13618 could not be substantiated. No regulatory deficiencies were found. The investigation into the complaint included: Observation of residents, including resident of concern; and interactions between residents and employees.	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:

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	Interviews with residents, including the resident of concern, Caregivers, Housekeepers, the Business Office Manager, the Resident Care Coordinator and the Administrator. Clinical record review of residents, including resident of concern. Document review of facility policies and procedures.			