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
	11459	A. BUILDING ____________________ B. WING ______________________	**03/10/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OHANA SENIOR LIVING CARE 1	**6825 WHITE SANDS AVE, LAS VEGAS, NEVADA ,89145**

(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 (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 a complaint investigation initiated at your facility on 03/10/26. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons and Mental Illness, Category II residents. The census at the time of the survey was seven. Eight resident files and four employee files were reviewed. The facility received a grade of A. There were two complaints investigated. Unsubstantiated: 1. Complaint # NV00013120 could not be	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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	substantiated. No regulatory deficiencies could be identified. 2. Complaint #NV00013163 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaint included: Observations of staff interaction with residents, residents in their room, the laundry room, the caregiver area, and a tour of the facility. Interviews were conducted with residents, a Caregiver, and the Administrator. Clinical Record Review of eight records, which included the resident of concern. Document review included facility policy and procedures, review of facility complaint log, and employee training records.			