STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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 0001-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. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey and complaint investigation survey initiated at your facility on 08/12/26 and completed on 09/02/26. The facility is licensed for 102 Residential Facility for Group beds for elderly and disabled persons and/or Assisted Living Services, Category II residents and 20 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's Disease, Category II residents. The census at the time of the survey was 116. The sample size was 25. The facility received a grade of A There were four complaints investigated. Unsubstantiated: 1.Complaint #14163 was unsubstantiated. Substantiated without deficient practice: 2.Complaint #13845 was substantiated with no deficient practice. Substantiated:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	3.Complaint #13970 was substantiated. See Tags 820 4. Complaint #14284 was substantiated. See Tag 526. The investigation of the complaints included: Observation of grooming, resident activities, clothing and appearance of residents, availability and use of lifts, meal service in resident rooms, call light response times, and a tour of the facility. Interviews were conducted with Residents, Caregivers, Registered Nurse, hospice case manager, Medication Technicians, the Wellness Director, and the Administrator. Clinical Record Review of 25 records, which included the Resident(s) of Concern. Document Review included facility policies and procedures, facility financial records, staff training records, the facility's incident report database, a sample admission agreement and resident inventory logs.			
Y 0526 SS= D	NAC 449.260 and RO43-22 Activities for residents. 1. The caregivers employed by a residential facility shall: (a)Ensure that the residents are afforded an opportunity to enjoy their privacy, participate in physical activities, relax and associate with other residents; (b)Provide group activities that provide mental and physical stimulation and develop creative skills and interests;	Y 0526	**1. Corrective actionfor the resident(s) affected:** Resident #2's activity needs and ability toparticipate will be reassessed. When the resident cannot attend scheduled groupactivities, staff will offer appropriate bedside/in-room activities based onthe resident's interests and capacities. Staff will document each offer,participation, refusal, and the type of activity provided. **2. Identification andcorrection for other residents who may be affected:** The ActivityDirector/designee will review all current residents who are bedbound,temporarily confined to their rooms, or otherwise unable to attend	09/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	(c) Plan recreational opportunities that are suited to the interests and capacities of the residents; (d) Provide each resident with a written program of activities; (e) Provide for the residents at least 10 hours each week of scheduled activities that are suited to their interests and capacities; (f) Encourage each resident to participate in the activities scheduled pursuant to his or her person-centered service plan; and (g) Post, in a common area of the facility, a calendar of activities for each month that notifies residents of the major activities that will occur in the facility. The calendar must be: (1) Prepared at least 1month in advance; and (2) Kept on file at the facility for not less than 6 months after it expires Inspector Comments: Based on observation and interview, the facility failed to ensure activities were made available to a resident who was physically unable to attend for 1 of 25 sampled residents. (Resident #2) On 09/02/26 in the morning, an exercise activity was observed in progress in the facility. R2 was not present at the activity. Resident #2 (R2) R2 was admitted on 07/17/26 with diagnoses including congestive heart failure and diabetes. On 09/02/26 in the morning, R2 was in		groupactivities to ensure they have an individualized means of participating inactivities. Any missing activity documentation or unmet activity needs will becorrected. **3. Systemic changesto prevent recurrence:** The facility will maintain at least 10 hours perweek of scheduled activities suited to residents' interests and capacities,maintain the monthly activity calendar, and ensure residents unable to attendgroup programs are offered individualized or in-room activities. Caregivers andactivity staff will be educated on documenting activity offers, participation,refusals, and alternative activities. Activity needs will be reflected in theresident's service planning as appropriate. **4. Monitoring /Quality Assurance:** The Activity Director/designee will audit residentsunable to attend group activities weekly for 12 weeks, then monthly for 3months. Audits will verify that appropriate activities were offered anddocumented. Findings will be reviewed by the Administrator and correctiveeducation will be provided for identified deficiencies. **5. Responsibleperson:** Administrator and Activity Director/Designee **6. Completion date:** September26, 2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	their room. R2 relayed they had not been able to attend resident activities due to not being helped out of bed and activities were not performed in their room. R2's record lacked documented evidence of R2 participating in resident activities or having activities performed in their room. On 09/02/26 in the morning, the Administrator and the Wellness Director were unable to confirm R2 had attended resident activities or had been provided activities in R2's room. Severity: 2 Scope:1 Complaint #14284			
Y 0820 SS= D	**NAC 449.2734 and R089-24 Residents having tracheostomy or open wound requiring treatment by a medical professional; residents having pressure or stasis ulcers.** 1. Except as otherwise provided in NAC 449.2702, a person who has a tracheostomy or an open wound that requires treatment by a medical professional must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The wound is in the process of healing or the tracheostomy is stable or can be cared for by the resident without	Y 0820	**1. Corrective actionfor the resident(s) affected:** Resident #18 is no longer identified in thesurvey as remaining at the facility. For any current resident with apressure/stasis ulcer or other qualifying wound, the Wellness Director/designeewill immediately verify a current physician diagnosis/order, confirm that woundtreatment and reassessment are being provided by an appropriately trainedmedical professional, and ensure required records are maintained at thefacility. Any gap in medical-professional wound care will be reported promptlyto the physician and appropriate medical provider for direction. **2. Identification andcorrection for other residents who may be affected:** The WellnessDirector/designee will complete a facility-wide review of current residents forwounds, pressure injuries, stasis ulcers,	09/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	assistance; (b) The care is provided by or under the supervision of a medical professional who has been trained to provide that care; or (c) The wound is the result of surgical intervention and care is provided as directed by the surgeon. 2. If a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer is admitted to a residential facility or permitted to remain as a resident of a residential facility: (a) The condition must have been diagnosed by a physician; (b) The condition must be cared for by a medical professional who is trained to provide care for and reassessment of that condition; and (c) Before a caregiver provides care to a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer, the caregiver must receive training related to the prevention and care of pressure sores from a medical professional who is trained to provide care for that condition. 3. The administrator of the facility shall ensure that records of the care provided to a person who has a pressure or stasis ulcer pursuant to subsection 2 are maintained at the facility. The records must include an explanation of the cause of the pressure or stasis ulcer. Inspector Comments: Based on record review and interview, the		or risk of pressure injury. Foridentified residents, records will be checked for physician diagnosis/orders,medical-professional wound care and reassessment, caregiver training whereapplicable, and wound-care documentation. Any deficiency will be addressedimmediately with the physician/home health/hospice or other appropriate medicalprovider. **3. Systemic changesto prevent recurrence:** An admission and change-of-condition wound screeningprocess will be implemented. Before accepting or retaining a resident with apressure/stasis ulcer or qualifying open wound, the Wellness Director/designeewill verify that the resident meets applicable requirements and that anappropriate medical professional is arranged to provide required care andreassessment. Caregivers providing permitted supportive care will receiverequired pressure-sore prevention/care training from a qualified medical professionalbefore providing such care. The facility will maintain wound-related orders,assessments, treatment records, provider information, and documentation of thecause of pressure/stasis ulcers as required. **4. Monitoring /Quality Assurance:** The Wellness Director/designee will audit all residentswith wounds or pressure-injury risk weekly for 12 weeks, then monthly for 3months. The audit will verify current orders, professional wound-carevisits/reassessments, required staff training, and complete documentation.Missed visits or documentation gaps will be escalated immediately to theAdministrator and the resident's physician/provider. **5. Responsibleperson:** Administrator and Wellness Director/Designee **6. Completion date:** September26, 2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	facility failed to ensure a medical professional provided wound care for a resident who had a stage 3 pressure ulcer for 1 of 25 sampled residents. (Resident #18). Findings include: Resident #18 (R18) R18 was admitted on 06/24/26 with diagnoses including acute chronic respiratory failure with hypoxia and heart failure. R18's record documented R18 was admitted to the facility from a skilled nursing facility. R18's record revealed a physician's order from a local skilled nursing facility dated 06/15/26 for Silver Sulfadiazine 1% topical cream, apply to sacrum topically every Tuesday, Thursday and Saturday and apply to sacrum topically as needed for Wound Care. R18's record revealed a history and physical from a local skilled nursing facility dated 06/15/26 relaying R18 was diagnosed with a pressure wound of the sacral area, stage three. R18's record lacked documented evidence of wound care being provided by a medical professional from admittance on 6/24/26 to 7/14/26 when R18 was assessed by a Registered Nurse (RN) from a hospice agency. R18's record revealed the hospice skin assessment dated 07/14/26 documented R18 had a skin condition and impairment, a pressure ulcer in the sacral area and treatment was to include turning/repositioning, pressure ulcer care, application of nonsurgical dressings and application of ointments/medications. R18's record revealed a hospice order dated 07/14/26 prescribing Silver Sulfadiazine 1% topical cream, apply to sacrum topically every Tuesday, Thursday			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	and Saturday. R18's record revealed a history and physical dated 07/16/26 from the hospice agency documented R18 had regular skin, soreness on their sacral area and had a stage 3 sacral pressure injury. On 08/24/26 in the afternoon, the ROC's hospice company who performed the assessments on R18 reported the agency did not provide wound care visits for R18 as R18 was under their care for only one week. R18 received two visits from a hospice nurse, one for an initial assessment on 07/14/26 and the second on 07/16/26 for lower extremity pain. R18's Medication Administration Record (MAR) for June 2026 and July 2026 revealed R18's Silver Sulfadiazine 1% topical cream was administered every Tuesday, Thursday and Saturday as prescribed by a Medication Technician. On 08/12/26 in the afternoon and 09/02/26 in the morning, the Wellness Director confirmed R18 had a wound present upon admission. On 08/12/26 and 09/02/26 in the morning, the Administrator denied R18 was admitted with a wound. On 09/03/26 in the afternoon, the Wellness Director relayed R18 was admitted to the facility using a Home Health company, which R18's POA abruptly changed to a hospice company after seven days at the facility. The Wellness Director relayed R18 should have been sent to the hospital for an assessment and should not have gone weeks without a wound care from a medical professional. On 09/08/26 in the morning, a Registered Nurse from the hospice agency explained the agency would have continued assessing R18's wound and would have performed wound care had R18 remained a the their care. Severity:2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	Scope: 1 Complaint #13970			
Y 0930 SS= D	**NAC 449.2749** **Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.** 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him. (c) A statement of the resident's allergies, if any, and any special diet or medication he requires. (d) A statement from the resident's physician concerning	Y 0930	**1. Corrective actionfor the resident(s) affected:** Resident #4's physician/appropriate medicalprovider will be notified of the resident's refusal and the facility willobtain and document appropriate follow-up direction. The facility will againoffer the required screening and document the offer, the resident'sresponse/refusal, notifications, education provided, and any alternativeevaluation or follow-up ordered by the medical provider. **2. Identification andcorrection for other residents who may be affected:** The WellnessDirector/designee will audit all current resident records to identify residentswhose required TB screening/documentation is due, overdue, missing, or refused.Any identified issue will be followed up promptly and documented in theresident's record. **3. Systemic changesto prevent recurrence:** A resident health-document tracking system will bemaintained with due dates and advance reminders for required screenings andassessments. Staff responsible for resident records will be educated onmaintaining complete resident files and documenting refusals, providernotification, follow-up instructions, and completed screening results. Theresident file audit checklist will include TB documentation. **4. Monitoring /Quality Assurance:** The Wellness Director/designee will review theTB/health-document tracking log monthly for 6 months and audit a sample ofresident files for timely screening and complete documentation. Any overdueitem will be addressed immediately and reported to the Administrator. **5. Responsibleperson:** Administrator and Wellness Director/Designee	09/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. (f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to		**6. Completion date:** September26, 2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i)The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility. 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death. 3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau. Inspector Comments: Based on record review and interview, the facility failed to ensure a tuberculosis (TB) test was completed annually for 1 of 25 residents (Resident #4). Findings include: Resident #4 (R4) R4 was admitted on 07/25/25, with a diagnosis of anxiety disorder. Review of R4's medical record revealed R4 completed a TB screening on 06/16/25 with a negative result. There was no documented evidence R4 completed a TB screening for 2026. On 08/12/26 in the afternoon, the Wellness Director acknowledged R4's record lacked documented evidence of an annual TB for 2026. According to the Wellness Director, R4 had refused to take an annual TB test. Severity: 2 Scope: 1			
Y 0950 SS= D	**NAC 449.275 Residential facility that provides hospice care: Responsibilities of staff; retention of resident with special medical needs.** 1. A residential facility may admit a resident who requires skilled nursing on a 24-hour basis, including, without limitation, such a resident who is bedfast, or permit	Y 0950	**1. Corrective actionfor the resident(s) affected:** Resident #18 is identified in the survey asdischarged. For every current resident receiving hospice services, the WellnessDirector/designee will verify that a copy of the current hospice plan of careand hospice-related orders and records are maintained at the facility. Missingdocuments will be requested from the hospice provider immediately. Facilitystaff will maintain written documentation of care and services provided andreport deviations from the	09/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	such a resident to remain in the facility without obtaining permission pursuant to NAC 449.2736 if: (a) The facility is not otherwise prohibited from admitting the resident or allowing the resident to remain in the facility, as applicable, by NAC 449.2702; (b) The care and services are provided by a program of hospice care or an agency to provide nursing in the home, as applicable; and (c) The facility complies with the requirements of subsection 2, if applicable. 2. A residential facility that provides services to a resident who elects to receive hospice care shall obtain a copy of the plan of care required pursuant to NAC 449.0186 for that resident. The members of the staff of the facility shall: (a) Maintain at the facility a written record of the care and services provided to a resident who receives hospice care; and (b) Report any deviation from the established plan of care to the resident's physician within 24 hours after the deviation occurs. Inspector Comments: Based on record review and interview, the facility failed to maintain a hospice record for 1 of 25 sampled residents. (Resident #18) Findings include: Resident #18 (R18) R18 was admitted on 06/24/26 with		established hospice plan of care to the resident's physicianwithin the required timeframe. **2. Identification andcorrection for other residents who may be affected:** The WellnessDirector/designee will audit every current hospice resident's facility recordto verify the presence of the hospice plan of care, physician orders, hospicecontact information, visit/treatment documentation, and facility documentationof care and services. Missing records will be obtained and filed. **3. Systemic changesto prevent recurrence:** A hospice-record checklist will be completed athospice enrollment and whenever there is a change in hospice provider or planof care. Original facility records will remain at the facility; copies may beprovided to authorized persons in accordance with confidentiality requirements.Staff will be educated on hospice record retention, documenting care/services,and reporting deviations from the hospice plan of care to the physician within24 hours. **4. Monitoring /Quality Assurance:** The Wellness Director/designee will audit all hospiceresident records weekly for 12 weeks, then monthly for 3 months. Audits willverify that the current hospice plan of care, orders, treatment/visitdocumentation, and facility care records are present. Any missing documentationwill be requested immediately and audit findings will be reviewed by theAdministrator. **5. Responsibleperson:** Administrator and Wellness Director/Designee **6. Completion date:** September26, 2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING _____ B. WING _____	09/02/2026

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

(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
	diagnoses including acute chronic respiratory failure with hypoxia and heart failure. R18 was enrolled with a hospice company as of 07/14/26. On 08/12/26 in the morning, R18's record lacked documented evidence of a hospice record, including no documentation of physician's orders for services provided and wound care treatment documentation. On 09/02/26 in the morning, the Wellness Director revealed R18's Power of Attorney requested R18's hospice record and never returned the record prior to R18's discharge. On 08/12/26 in the morning, the Wellness Director confirmed there was no hospice record on site for R18. Severity: 2 Scope: 1			