STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tlc Care Center	1500 W Warm Springs Rd Henderson, NV 89014

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure target behaviors and side effects were monitored with regards to use of an anti-psychotic medication for 1 of 7 sampled residents (Resident 1). The deficient practice had the potential to place the residents at risk for receiving unnecessary medications.Findings include:The Anti-psychotic Medication Use policy (undated), documented residents admitted already receiving anti-psychotics would have been evaluated for its appropriateness and indication for use. The inter-disciplinary team (IDT) assessed the residents' symptoms and overall situation, and the physician determined whether to continue, adjust, or stop the antipsychotic medication.Resident 1 (R1) was admitted on [DATE], with diagnoses including metabolic encephalopathy, malignant neoplasm of the colon and non-traumatic subarachnoid hemorrhage.The admission minimum data set (MDS) dated [DATE], revealed R1 was cognitively intact, had verbally aggressive behaviors and was receiving an anti-psychotic medication.A physician order dated 04/15 /2025, documented to give Quetiapine Fumarate (anti-psychotic) oral Tablet 25 milligrams (mg) one tablet by mouth at bedtime for bipolar disorder as manifested by (AMB) mood swings.A physician order dated 04/29/2025, documented to monitor behavior of mood swings for anti-psychotic medication Quetiapine. Use non-pharmacological intervention codes: (1) redirect; (2) one-on-one 1:1; (3) activities; (4) toilet; (5) give food or fluids; (6) reposition; (7) back rub; (8) other chart in progress notes. Outcome Code: (+) effective (-) ineffective every shift.A physician order dated 04/29/2025, documented to monitor for side effects of anti-psychotic medication Quetiapine: dry mouth, constipation, blurred vision, disorientation, confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea, vomiting, lethargy, drooling, extra pyramidal symptoms (EPS) symptoms (tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue), every shift for bipolar disorder manifested by mood swings.The medical record lacked documented evidence target behaviors and side effects were monitored from 04/15/2025 to 04/28/2025.On 03/04/2026 at 9:34 AM, a Licensed Practical Nurse (LPN) assigned to R1's unit indicated not being familiar with R1 due to being newly hired at the facility. The LPN explained all psychoactive medication orders were entered with specific target behaviors and side effect monitoring for the purpose of guiding providers on whether the medication and dosage continued to be appropriate for the resident. The LPN reviewed R1's medical record and confirmed R1 started receiving Quetiapine on 04/15/2025 but behavior monitoring and side effect monitoring were not initiated until 04/29/2025. The LPN confirmed physician orders to monitor target behaviors such as mood swings and side effects such as dry mouth and blurry vision were not entered until 04/29/2025 but the LPN could not speak to why this was the case.On 03/04/2026 at 10:18 AM, a charge nurse vaguely recalled R1 who was at the facility briefly a year ago. The charge nurse reviewed R1's medical record and stated the admitting nurse who entered R1's Quetiapine order on 04/15/2025 may have forgotten to enter orders for behavior and side effect monitoring. The charge nurse indicated the medication administration record (MAR) reflected R1 started receiving Quetiapine on 04/15/2025 but target behavior of mood swings and potential side effects were not monitored until 04/29/2025 which may have been due to monitoring orders being entered only on 04/29/2025. The charge nurse clarified (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders which were not entered into the electronic health record (EHR) would not prompt the floor nurses to view a medication or task which as due.On 03/04/2026 at 10:30 AM, the charge nurse explained residents receiving psychoactive medications were monitored for target behaviors and potential side effects for the purpose guiding the clinician on whether the medication, frequency and dosage were appropriate or whether a dose reduction was appropriate.On 03/04/2026 at 1:55 PM, the Director of Nursing (DON) indicated having reviewed R1's record and confirmed R1 was not monitored for target behaviors and potential side effects from 04/15/2025 (first dose of Quetiapine) until 04/29/2025 due to monitoring orders being entered two weeks late.On 03/04/2026 at 2:00 PM, the DON indicated the purpose of monitoring behaviors and side effects for residents receiving any psychoactive medications were to ensure the medication, dosage and frequency were still appropriate for the residents. This also served as a guide for pharmacy and providers with regards to gradual dose reductions (GDRs) or changes to the medicationsThe facility's Tapering medications and Gradual Dose Reduction policy (undated), documented tapering applicable to anti-psychotic medications shall be referred to as GDR. The attending physician identified target symptoms for which the resident was receiving the medication. The staff monitored the improvement of target symptoms and provided the physician with the information. The physician in collaboration with nursing and pharmacy would periodically review whether the medications were still necessary in their current doses.Facility Reported Incident 2646420