STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026
NAME OF PROVIDER OR SUPPLIER Tlc Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure residents did not feel like their privacy rights were violated related to an unauthorized video recording and subsequent social media release by a resident's family member for 10 of 21 sampled residents (Resident 1, 2, 3, 7, 10, 11, 15, 18, 19, and 21). The deficient practice placed residents and/or representatives at risk for exploitation.Findings include: On 03/20/2026 at 8:30 AM, the Director of Nursing (DON) indicated a fire occurred on 03/08/2026 which came from the ceiling in the dining room. The DON explained the Code Red was called during lunch service, and residents were assisted to the outdoor courtyard. The doors remained closed during activation of the fire protocol which caused a resident's family member to be upset over not being allowed to enter the facility from the courtyard. The resident's family member started video recording the incident which captured multiple residents without consent and uploaded the video to social media. A review of the 45 second social media posting showed multiple residents, staff members and visitors which included minors. The resident's family member who uploaded the video included a long narrative, stating We gonna go internet viral let's do it! Yes, all these people just sitting in here with the AC. They are talking about there is a fire here, but they are just chilling. (Camera moves to courtyard towards residents) While these old people are outside, disabilities, they try to come in and they shoo-ing them away like dogs. Check this out. Ridiculous!As of 03/20/2026 at 8:49 AM, the social media post viewed alongside the DON garnered 1,020 comments, 12,800 likes, 841 shares, and 754 shared collections with friends.The DON provided a list of residents who were identified to be in the courtyard at the time of the incident.Resident 1 (R1)R1 was admitted on [DATE] and readmitted on [DATE], with diagnoses including acute on chronic respiratory failure and chronic obstructive pulmonary disease (COPD).An incident summary for resident/family notification of unauthorized recording and social media posting dated 03/18/2026, revealed R1 felt upset and stated the individual should have warned everyone.Resident 2 (R2)R2 was admitted on [DATE], with diagnoses including cerebral infarction and encephalopathy, gastrostomy status and tracheostomy status.An incident summary for resident/family notification of unauthorized recording and social media posting signed by R2's family member on 03/18/2026, documented the family member did not want to be in the video and would have wanted to be able to give consent. R2 and this family member were in the video.Resident 3 (R3)R3 was admitted on [DATE], with diagnoses including protein-calorie malnutrition and absence of right leg above knee and left leg above knee.On 03/20/2026 at 10:22 AM, R3 confirmed being evacuated into the courtyard during the fire incident indicated viewing the social media post where R3 identified self in the footage. R3 indicated witnessing a staff member telling the person who was filming to stop filming, but the person continued to film which R3 found inappropriate. R3 indicated the facility should take legal action against the perpetrator.Resident 7 (R7)R7 was admitted on [DATE], with diagnoses including cerebral palsy and other seizures.On 03/20/2026 at 10:52 AM, R7 confirmed being evacuated to the courtyard during the fire incident. R7 indicated taking offense to the person who filmed the incident without consent and would be satisfied if the facility took legal action towards this person.Resident 10 (R10)R10 was admitted on [DATE], with diagnoses including schizoaffective disorder.On 03/20/2026 (continued on next page)

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.

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 10:35 AM, R10 confirmed being one of the residents evacuated one Sunday. R10 indicated being informed by the facility that a visitor filmed the incident and posted the video on social media. R10 indicated feeling the individual violated R10's privacy. R10 indicated being satisfied if the facility took legal action against the perpetrator.Resident 11 (R11)R11 was admitted on [DATE], with diagnoses including Parkinson's disease.On 03/20/2026 at 10:41 AM, R11 indicated if someone took a video of them without consent and posted on social media they would take offense. R11 indicated being content if the facility took legal action against this person.Resident 15 (R15)R15 was admitted on [DATE], with diagnoses including pleural effusion and bipolar disorder.On 03/20/2026 at 10:03 AM, R15 confirmed being evacuated by staff from the dining room to the courtyard a while ago. R15 indicated social services informed R15 a visitor filmed the incident and posted the video on social media. R15 stated, that was uncool and indicated feeling violated but at the same time was not surprised as it was the age of social media. R15 stated they would be satisfied if the facility pursued legal action against the perpetrator.Resident 18 (R18)R18 was admitted on [DATE], with diagnoses including atrial fibrillation.On 03/20/2026 at 9:35 AM, R18 indicated being one of the residents who were evacuated to the courtyard during a fire a few weeks ago. R18 indicated feeling their privacy was violated when informed of unauthorized recording posted on social media. R18 indicated the facility should take legal action against the individual on behalf of the residents.Resident 19 (R19)R19 was admitted on [DATE] with diagnoses including polyneuropathy and unspecified dementia.On 03/20/2026 at 11:09 AM, the social services director (SSD) indicated R19 who was under public guardianship was in the courtyard on 03/08/2026. The SSD reached out to the public guardian who expressed not liking a video of R19 being taken without consent. The guardian emphasized not wanting any more incidents of residents recorded without consent and posted on social media.Resident 21 (R21)R21 was admitted on [DATE], with diagnoses including schizophrenia and unspecified dementia.On 03/20/2026 at 11:15 AM, the SSD indicated reaching out to R21's responsible party since R21 had dementia. According to the SSD, R21's family member expressed not liking R21 being in the video without the family member's consent and did not like R21 to be used by the individual for a social media video.On 03/20/2026 at 11:16 AM, the SSD indicated there were about 20 residents involved in the unauthorized recording on 03/08/2026 and subsequent social media release of the footage. The SSD indicated interviewing the residents and/or their responsible parties, four of whom were public guardians. The SSD indicated completing a form titled Resident/Family Notification Documentation of Unauthorized Recording/Social Media Posting after the incident all residents who appeared in the video and forwarded findings to the Assistant Administrator who was in charge of submitting incident reports to state agency.On 03/20/2026 at 11:37 AM, the Administrator indicated resident interviews resulted in a decision the incident was reportable due to its potential for privacy violation or construed as mental abuse related to privacy.The facility's Videotaping, Photographing, and other Imaging of Residents policy dated 10/01/2021, documented transmitting unauthorized images of any resident through email, internet, or social media was considered a violation of resident's rights. Any image or recording taken may be construed as humiliating or demeaning to a resident or residents was considered resident abuse and should be reported and investigated as such. The facility took the following corrective actions since the incident on 03/08/2026:-A letter to families dated 03/112026, documented the Administrator released a letter to residents and families regarding the incident of unauthorized footage circulating on social media involving residents during a fire evacuation incident and made clarifications to inaccurate information circulating in social media and wanted to ensure residents were informed 1) a mechanical issue with an AC unit belt caused a small amount of smoke to enter the dining room, 2) an evacuation occurred where residents were assisted to courtyard, 3) water was offered to residents who were not allowed to re-enter until fire dept cleared code, 4) professional clearance was obtained, 5) the privacy and safety of residents were highest priority.-Staff training on HIPAA and Management and Protection of protected health information (PHI) was provided to staff and corroborated by in-service sign-in (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sheets- Signages were posted in high visibility areas Due to patient privacy, no photography or video- The Administrator, under the guidance of the corporation's legal team has contacted two law offices to initiate filing a lawsuit against the person who filmed the video without consent and posted the video on social media-The person who filmed the video without permission was no longer allowed to visit the resident of concern. This was the request of the resident of concern's responsible party who was also related to the alleged individual.FRI 2959459

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, record review and document review, the facility failed to ensure a 1) fire incident and 2) an incident of unauthorized video recording and social media release of multiple residents by a resident's family member were reported timely to the state agency. The deficient practice placed residents at risk for delayed emergency response and potential violation of privacy. Findings include: Fire incidentOn 03/08/2026 at 12:50 PM, a maintenance assistant observed smoke from a ceiling vent in the facility's main dining room and a burning electrical odor. The assistant activated the fire alarm, and additional staff evacuated residents to the courtyard. The fire department responded and identified the source as a seized heating, ventilation and air conditioning (HVAC) fan blower motor, the belt generated smoke briefly until failure. The Fire Department confirmed there was no fire or heat, and no injuries or suppression activity occurred. Power to the unit has been secured and replacement was pending.During the investigation, the surveyor observed the 3,363 square feet main dining room is only protected by a single photoelectric smoke detector at the entrance (egress coverage). The remainder of the space in its entirety, including the tray ceiling, lacked detection. This suggested the absence of a performance-based design assessment, resulting in inadequate coverage under a spot detection approach.This condition appeared inconsistent with NFPA 72 (2010) Section 17.7.3.2.1, and the space should be reevaluated to ensure compliant and adequate smoke detection coverage.The facility submitted report of this incident to the state agency on 03/19/2026 (11 days after the incident).Unauthorized recording and social media releaseA facility report dated 03/19/2026, revealed a code red was called 03/08/2026 for unidentified smoke in the dining room. The residents were immediately evacuated to the outdoor courtyard. While waiting for clearance from the fire department, a resident's family member began recording unauthorized video footage containing faces of residents without their consent.On 03/20/2026 in the morning, staff and resident interviews, review of social media footage and documents provided by the facility confirmed there was unauthorized videotaping of multiple residents without consent and subsequent social media release.The facility submitted a report of the incident on 03/19/2026 (11 days after the incident).The facility's Videotaping, Photographing, and other images of resident's policy dated 10/01/2021, documented transmitting unauthorized images of any resident through email, internet or social media was considered violation of resident rights. Any images, recordings taken may be construed as humiliating or demeaning to a resident or residents, was considered abuse and should be reported and investigated as such.The facility's Abuse policy defined exploitation as taking advantage of a resident for personal gain. Incidences of abuse should be reported to the state survey agency no later than 24 hours if the events which caused the suspicion did not result in serious bodily harm. FRI 2959459