

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/05/2026
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.			
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to:1) Maintain sufficient and adequate linen supplies;2) Ensure a sanitary, clean and homelike environment of resident rooms;3) Maintain the cleanliness of shower rooms and resident care areas; and4) Ensure resident equipment, including a footboard, was maintained in good repair.This deficient practice had had the potential to encourage pathogen growth, spread infection, compromise resident comfort, dignity, and hygiene, and could interfere with the provision of timely and appropriate care.Findings include: On 06/02/2026 at 9:33 AM, a tour of the 200-Hall revealed the following: -room [ROOM NUMBER]; floors and walls were soiled with dark colored splatter of brownish/reddish areas of an unknown substance throughout and multiple nails in walls with no hanging items. -room [ROOM NUMBER], 212, and 214 the privacy curtain was soiled with a large brown colored area and multiple smaller brown colored areas of an unknown substance. On 06/02/2026 at 10:48 AM, a tour of the 300-Hall revealed the privacy curtain was soiled with a large brown colored area of an unknown substance in Rooms 300, 301, 302 and 304. On 06/02/2026 at 2:08 PM, room [ROOM NUMBER] was observed with floors and walls soiled with dark colored splatter and brownish/reddish areas of an unknown substance throughout multiple areas. On 06/02/2026 at 2:09 PM, a certified nursing assistant (CNA1) explained the walls appeared dirty and soiled with possible food and/or bodily fluids and should have been cleaned by housekeeping staff. The CNA1 indicated they would typically clean something like that when observed if housekeeping staff were not in the unit. On 06/02/2026 at 2:13 PM, a housekeeping aide explained being responsible for all rooms in the 200-unit hallway and rooms were cleaned daily. The daily cleaning consisted of light switches, walls, air conditioner unit, window frame, bed rails, foot/head of bed, and wiping the closet/nightstand and bedside table. A deep cleaning of the resident rooms was done at discharge. The housekeeping aide indicated they had just cleaned the walls and floors in room [ROOM NUMBER]. The housekeeping aide confirmed room [ROOM NUMBER] still had multiple spots and areas on the walls which required more cleaning. The housekeeping aide indicated the resident who occupied room [ROOM NUMBER] was known to spit on the walls and hawk loogies. The housekeeping aide explained a lot of what was cleaned off the wall earlier was loogies or mucus globs, spit, food, and blood. On 06/04/2026 at 2:41 PM, the housekeeping assistant supervisor explained the expectation for (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleaning resident rooms, shower rooms, lobby, eating areas, trash, floor sweeping/mopping was to be done daily. The housekeeping assistant supervisor explained deep cleaning for scrubbing baseboards, wiping down walls, and wiping food stains was done as needed. On 06/04/2026 at 3:13 PM, the environmental services (EVS) director explained curtains were washed/switched out as needed when soiled or stained. When a new resident was admitted , housekeeping would observe the room and curtain and notify laundry if needed to be replaced or cleaned. If the curtain was not dirty or soiled it would not be switched out on a routine basis. No log was kept. The EVS Director explained walls and bedrails in the resident rooms were cleaned daily. The facility's Homelike Environment policy (undated), documented residents would be provided with a safe, clean, comfortable and homelike environment. Characteristics of the facility that reflect a personalized, homelike setting include a) clean, sanitary and orderly environment and e) clean bed and bath linens that are in good condition. On 06/02/2026 at 7:50 AM, a tour of the 900-Hall revealed the following: - the floors were filthy with old and new dirt stains more pronounced at the corners of the wall by the base boards. A certified nursing assistant (CNA) confirmed the floors were dirty throughout the unit because the housekeeper in the 900-Hall quit. - debris such as plastic, ports and foil were observed on the floor. - shower room where floors were dirty with wheelchair tracks and discoloration built-up between tiles. - a dirty linen was found in the clean hand-washing sink inside the shower room. - broken equipment was stored in the shower room, namely, one wooden rocking chair, two gray bedside commodes, bedside table with wheelchair parts on top. - three trash bins without plastic bags. On 06/02/2026 at 8:57 AM, the CNA confirmed the shower room was cluttered which contributed to the unsanitary condition and obstructed movement of residents within the shower room. not in use. On 06/02/2026 9:23 AM, Resident 219 (R219) laid in bed alert. The foot board was detached from the bed and leaning on the wall by the air-conditioning unit. R219 indicated complaining about the broken foot board for six months and the staff members would just push the foot board back in and it would fall again. The CNA indicated the issue had been reported to maintenance staff this morning and the maintenance staff instructed the CNA to push the foot board back into bed. On 06/03/2026 at 1:10 PM, the Unit Manager confirmed the unit was not maintained in a sanitary manner, floors were dirty, and the shower room was cluttered with broken equipment. The Unit Manager could not speak to why the 900-Hall shower room was being used as storage of broken equipment. On 06/03/2026 at 1:13 PM, the Assistant Director of Nursing (ADON) explained the facility faced challenges with housekeeping services. Housekeeping staff were employed and not contracted and (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occasionally short-staffed. The ADON stated residents deserved to live in a clean environment and the unit and the shower rooms should have been maintained in a sanitary manner for residents. On 06/04/2026 at 1:45 PM, the housekeeping assistant supervisor confirmed being directly employed by facility and not contracted. The assistant supervisor explained the facility had nine units and there was one housekeeper assigned to each unit. The housekeeper assigned to the 900-Hall resigned and other housekeepers were helping doing their best to cover the 900-Hall. The assistant supervisor reviewed the housekeeping schedule and explained the housekeeper assigned to the 900-Hall on 06/02/2026 was also assigned to clean the lobby, front desk and nurse's station as well as 16 rooms in the 900-Hall as well as common areas. On 06/04/2026 at 1:56 PM, the housekeeping assistant supervisor explained housekeepers were responsible for routine cleaning of resident rooms in their assigned units, common areas such as showers and activity lounge and side tasks. On 06/04/2026 at 2:01 PM, the housekeeping assistant supervisor acknowledged housekeeping staff have expressed concerns regarding workload and time constraints which were difficult to meet within the 8-hour work shift. The assistant supervisor indicated there were currently two full-time housekeeping vacancies. The facility's Homelike Environment policy (undated), documented residents would be provided with a safe, clean, comfortable and homelike environment. On 06/02/2026 at 12:23 PM, observation of the Unit 500 linen closet revealed minimal stocked items, which were not adequate for the unit's needs. On 06/02/2026 at 12:26 PM, observation of the Unit 400 linen closet revealed bare minimum supplies, which were not adequate for the unit's needs. On 06/02/2026 at 8:28 AM, Resident 199 indicated the facility was always out of clean linens and chucks. The resident verbalized staff reported not having enough linen to change sheets and that his bed was changed once a week. On 06/02/2026 at 8:46 AM, Resident 132, indicated obtaining clean linen could be a concern at times and that the facility does not have enough chucks and blankets. On 06/02/2026 at 9:10 AM, Resident 249, indicated facility had a shortage of towels and blankets. On 06/02/2026 at 9:12 AM, Resident 248, voiced the facility had a shortage of towels and blankets and reported needing to obtain towels early to ensure they had one available for shower days. On 06/02/2026 at 9:20 AM, Resident 228, verbalized staff did not make the bed unless requested and there was little to no linen with an ongoing issue obtaining a blanket. On 06/02/2026 at 9:23 AM, Resident 207 indicated staff did not make the bed and the facility had a shortage of linen. The resident verbalized obtaining a blanket continued to be an ongoing issue. On 06/03/2026 at 7:32 AM, observation of the Unit 400 linen closet revealed minimal supplies, including seven towels, two sheets, two fitted sheets, one chuck, five gowns, one shower blanket, (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	three pillowcases, and six hand towels. This inventory was insufficient for a unit housing 24 active residents. On 06/03/2026 at 7:40 AM, observation of the Unit 500 linen closet revealed linen supplies at a bare minimum, consisting of two towels, one hand towel, four fitted sheets, one shower blanket, six pillowcases, eight gowns, and no chucks. This inventory was inadequate for a unit with 23 active residents. On 06/03/2026 at 7:54 AM, observation of the laundry room revealed three functioning washers and three functioning dryers. The clean linen area contained only one three-tier rack with eight gowns and lacked all other essential linens, including towels, blankets, chucks, fitted sheets, sheets, pillowcases, and hand towels. On 06/03/2026 at 7:33 AM, Licensed Practical Nurse (LPN), indicated the facility did not ensure sufficient linen availability for the unit. The LPN reported linen supplies were often below minimum and that residents experienced delays in receiving essential care needs. On 06/03/2026 at 7:34 AM, Certified Nursing Assistant (CNA), verbalized there was no linen available for resident use and that the lack of linen directly prevented staff from providing necessary and timely care. On 06/03/2026 at 7:41 AM, Certified Nursing Assistant (CNA), indicated linen supplies were consistently insufficient for the unit, resulting in delays in resident care. On 06/03/2026 at 7:42 AM, Licensed Practical Nurse (LPN), reported linen was normally unavailable, which negatively impacted residents and hindered the delivery of required care. On 06/03/2026 at 7:44 AM, Certified Nursing Assistant (CNA), reported the unit's linen supply was never fully stocked and frequently insufficient, leading to ongoing negative effects on the delivery of resident care. On 06/03/2026 at 7:57 AM, the Environmental Services (EVS) Director, stated that the facility had not received its blanket delivery and had no blankets available aside from shower blankets. On 06/03/2026 at 8:01 AM, the Environmental Services (EVS) Director, inspected the Unit 500 linen closet and acknowledged the current linen inventory was insufficient, confirming that adequate linen levels are necessary to ensure proper resident care. On 06/03/2026 at 8:05 AM, the Environmental Services (EVS) Director, inspected the Unit 400 linen closet and confirmed that the linen inventory was inadequate to support the unit's needs. The EVS Director stated that the available linen supply was not sufficient to meet resident care needs.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review the facility failed to implement its Drug Diversion Risk Tool for missing narcotics, for 1 of 64 sampled residents (Resident 272). The deficient practice had the potential to put residents at risk of physical harm. Findings include: Resident 272 (R272) was admitted on [DATE] with the diagnoses including polyneuropathy, unspecified severe protein-calorie malnutrition, major depressive disorder (recurrent), other osteoporosis without current pathological fracture, and other chronic pain. R272 resided in the 300-hall. On 06/02/2026 at 9:44 AM, a Registered Nurse (RN) indicated noticing R272's Norco (hydrocodone-acetaminophen) oral tablet 10-325 milligram (MG) punch card was missing from the medication cart on 03/17/2025. The RN reported immediately notifying the past Director of Nursing (DON) the Norco punch card was missing from the medication cart and Administration immediately started an investigation. The RN indicated the medication was signed for by a fellow Licensed Practical Nurse (LPN) on 03/13/2026 as having received it from the pharmacy. On 06/02/2026 at 11:07 AM, the LPN indicated working on the 200-hall on 03/13/2026 when the pharmacy delivered the medication to the nurses on the halls. The nurse from the 300-hall was not available as the nurse was on a break. The LPN indicated having had signed for both the 200-hall and 300-hall medications. The LPN also stored the the 300-hall medications in the 200-hall cart until the 300-hall nurse came back from break. The LPN expressed giving the nurse the medications for the 300-hall as soon as the nurse returned from a break. The LPN remembered the nurse putting the medications in the locked drawer of the medication cart. The LPN indicated around 03/17/2025 or 03/18/2025 Administration called them about the missing medication. The LPN verbalized Administration informed they may be required to have a drug test. The LPN was never drug tested and was unsure if the other nurse was drug tested. The LPN revealed the medication for R272 was a PRN medication which is why no medication doses were missed. The LPN was able to get the medication for R272 on the night of 03/17/2025. R272's Medication Administration Record documented no doses of Norco oral tablet 10-325 MG was given from the date the medication was received by the nurse on the 300-hall (03/13/2025) until 03/17/2025. On 06/02/2026 at 11:23 AM, the Lead Pharmacy Technician explained the Norco oral tablet 10-325 MG was available in the facility's pyxis machine (an automated, computer-controlled medication dispensing system) to dispense, so R272 could have still gotten the medication if needed. The employee file for the nurse in question documented due to a pattern of repeated issues of not following protocol and mis-handling narcotics, the facility was going to move forward with termination. On 06/02/2026 in the morning, the Human Resource (HR) Manager verified there was no documentation of the mishandling of narcotics being reported to the Board of Nursing, nor of the nurse involved being reported to the Board of Nursing. The HR Manager also verified there was no documentation of a drug test being performed on the alleged wrongdoer or an employee declining a drug test. On 06/05/2026 at 8:50 AM the Assistant Director of Nursing (ADON) confirmed if a nurse was terminated for a pattern of repeated issues of not following protocol and mis-handling narcotics, this would have been reported to the Board of Nursing. The ADON explained facility Administration would have been the ones to report the issue to the Board of Nursing. The facility provided a Drug Diversion Risk Tool for investigating possible nursing drug diversion. According to the tool, any suspicion of drug diversion was immediately reported to the Administrator, Director of Nursing, Regional [NAME] President of Operations and Regional Director of Clinical Services. The facility then notified the Department of Health, Law Enforcement and Area Agency on Aging (if applicable). The facility notified the pharmacy and reported the allegation to the Board of Nursing. Then, moved to Step One which involved removing the alleged wrongdoer from the facility and conducting a drug test. The process consisted of four total steps to reach a final determination.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure skilled services were maintained for a resident with an approved appeal for 1 of 64 Residents (Resident 276). The deficient practice had the potential for a resident not to receive the necessary skilled services to attain maximum potential and prevention from hospital readmission. Findings include: Resident 267 (R267) was admitted on [DATE], with diagnoses including cerebral infarction and cognitive communication defect. R267 Notice of Medicare Non-Coverage (NOMNC) had a last cover date (LCD) of 10/16/2025. Based on the LCD the beneficiary had a date of liability (date of discharge without accruing financial responsibility) of 10/17/2025. The NOMNC documented successful timely phone notification to R267's spouse on 10/14/2025. A Social Services R267 progress note dated 10/14/2025 NOMNC was issued on this date with the resident's spouse. NOMNC with a LCD of 10/16/2025 discharge date [DATE]. Appeal rights, financial responsibility and the deadline to file an appeal were all explained. Copy of the NOMNC was provided and uploaded in the PCC. Spouse verbalized understanding and states that she will file an appeal. A nursing progress note dated 10/17/2025 documented resident transferred to the home in community at 2:45 PM via ambulance. The resident left in safe stable condition, no evidence of distress prior to leaving. Resident transferred with all his remaining meds, and personal belongings. Left via MTC transport. An appeals determination letter dated October 16, 2027 (the day before liability date) with a successful transmittal fax cover sheet dated October 16, 2025 at 11:16 AM documented, it was determined that you require the continued services being provided by the facility. The medical records lacked documented evidence the facility had discussed with the resident or the resident representative the determination of the appeals organization and the care for R267 could be continued until a new NOMNC was provided by the resident's Managed Medicare plan. On 06/04/2026 at 3:40 PM, the case management (CM) confirmed the resident's appeal was approved and care should have been continued. The CM indicated the residents' spouse decided to discharge the resident. There was no documented evidence the resident's spouse was informed of the approved appeal and care could have been continued. There was no evidence a second NOMNC was issued. The CM agreed resident should not have been discharged and if the resident or resident's representative decided to be discharged, documentation of the conversation should have been reflected in the medical records. The facility policy titled Transfer or Discharge, Preparing a Resident for dated 10/01/2021, documented the business office and/or the social worker is responsible for informing the resident, or his or her representative of the facility's readmission, appeal rights, bed-holding policies and others as appropriate or as necessary.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to provide the documented evidence showers were provided to a resident for 1 of 64 sampled resident (Resident 228). The deficient practice had the potential to prevent resident from skin infections and exposing unhygienic conditions which can affect a resident's mental health, dignity, and overall immune response. Findings include: Resident 228 (R228) had an initial admission date of 03/23/2026, with diagnoses including malignant neoplasm of the colon and difficulty in walking. R228's point of care (POC) task charting documented a scheduled shower/bathe every Wednesday and Saturday on the 2:00PM to10:00 PM shift and as needed (PRN), entered on 03/23/2026. R228's POC showers encoded the following on the assigned shower days: 04/03/2026 &ndash; shower, supervision or touching assistance 04/07/2026 &ndash; NA 04/10/2026 - shower, supervision or touching assistance 04/13/2026 &ndash; Shower sheet 04/14/2026 &ndash; NA 04/17/2026 &ndash; NA 04/21/2026 &ndash; NA 04/24/2026 &ndash; Resident Refused (RR) 04/28/2026 &ndash; NA 05/01/2026 &ndash; Blank 05/04/2026 &ndash; Blank 05/08/2026 &ndash; RR 05/12/2026 &ndash; RR 05/15/2026 &ndash; RR 05/18/2026 &ndash; Blank 05/22/2026 &ndash; RR 05/25/2026 &ndash; Blank (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/26/2026 & Shower (PRN) 05/29/2026 - RR On 06/02/2026 at 3:00 PM, a certified nursing aide (CNA) indicated if a resident refused a shower. The nurse would be informed and attempts made to encourage the shower to be taken. The CNA would complete the shower form and give it to the nurse to complete. On 06/02/2026 at 3:20 PM, a license practical nurse (LPN) indicated they would attempt to encourage the resident to take the shower. If the attempt was not successful, the shower sheet would be completed and filed. The nurse would also document on to the progress notes on the resident's refusal and attempts were made to encourage the resident to receive the shower. On 06/03/2026 at 8:50 AM, an LPN indicated a shower sheet would be generated per shower. The assistant director of nursing (ADON) would pick up the shower sheets and filed separately. On 06/03/2026 at 9:00 AM, the ADON confirmed the shower sheets would be compiled and expectation a sheet generated per shower day regardless if the shower was given or refused. The ADON indicated the shower sheets was initiated not just a tool to track the residents shower but also to monitor assessments of skin conditions during shower days. On 06/03/2026 at 9:10 AM, the director of nursing (DON) indicated shower sheets were initiated due to the electronic healthcare record (EHR) not charting appropriately and recording it as NA. The facility had reverted to paper documentation due to the system not recording showers or the attempts accordingly. The expectation was shower sheets were generated per shower day. Review of R228's shower sheets revealed the resident only had one shower sheet (dated 04/13/2026) completed for the months of April 2026 and May 2026. The POC charting only documented a shower on 04/03/2026 and 04/10/2026 as Type of Bath: 1) Shower and 04) Supervision or touching assistance. The rest of the shower days were NA or RR. On 06/03/2026 at 2:45 PM, the director of nursing (DON) reviewed the resident shower sheets and POC charting. The DON agreed the NA documentation did not reflect the type of care provided or if the residents refused. The DON acknowledged the lack of shower sheets for the residents which should have been generated for each shower day. The DON indicated progress note should have been entered by the nurse if the resident had refused and the attempts to encourage. The DON acknowledged the lack of shower sheets or inconsistent entries at the EHR reflects the resident was not provided any shower attempts. The facility policy titled Shower/Tub Bath (undated), documented to notify the licensed nurse if the resident refused the shower/tub bath. If the resident refused the shower/tub bath, document the reasons why and the interventions taken. Complaint 2991411 Resident 108 (R108) was admitted on [DATE], with diagnoses including cerebral palsy and profound intellectual disability. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The annual minimum data set (MDS) dated [DATE], revealed R108 had impaired cognition and was dependent on staff for personal hygiene. On 06/02/2026 at 9:53 AM, a thick bandage dated 05/05/2026 was wrapped around R108's right forearm. The Licensed Practical Nurse (LPN) assigned to R108 indicated not knowing if R108 had scratching behaviors to right forearm. The LPN described R108's fingernails as thickened, about one-fourth inch above nail bed long, and yellowish. The LPN indicated R108 was special needs residents and would require podiatry services. On 06/03/2026 at 2:02 PM, the Unit Manager indicated R108 was not a diabetic and did not have complicated hands and/or fingernails and any certified nursing assistant (CNA) or nurse could cut R108's fingernails when observed to be long. The Unit Manager indicated a licensed nurse may be better for R108's fingernail trimming due to R108's uncontrolled movements related to cerebral palsy. On 06/03/2026 at 2:07 PM, the Assistant Director of Nursing (ADON) explained R108 was developmentally delayed and was not aware of behaviors such as scratching so nails must be kept short to prevent injury. The facility's ADL policy (undated), residents unable to carry out ADLs independently would receive all services necessary to maintain grooming, personal and oral hygiene. Resident 194 (R194) was admitted [DATE], readmitted [DATE], with diagnosis including encounter for attention to gastrostomy, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, and polyneuropathy. On 06/03/2026 at 2:30 PM, R194's fingernails were observed extending greater than 0.25 inch beyond fingertips on both hands. The right middle fingernail was observed significantly shorter than the remaining fingernails and extended only to the end of the nail bed. Multiple fingernails contained dark-colored matter beneath the nails. R194 stated wanted nails trimmed and confirmed had previously requested the nails to be trimmed. A minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13. R194 was cognitively intact. R194 was dependent on staff to maintain personal hygiene, including grooming activities. A Care Plan dated 05/18/2026, documented R194 required assistance with activities of daily living related to hemiplegia of the left side and limitations in range of motion and left upper extremity. On 06/03/2026 at 2:38 PM, a Registered Nurse (RN), confirmed R194's nails were excessively long. The RN explained certified nursing assistants (CNAs) were supposed to trim resident's fingernails. The RN acknowledged R194's fingernails were over 0.25 inch long and had not been trimmed recently. The RN acknowledged fingernails should have been trimmed to prevent R194 from scratching self with long nails. On 06/03/2026 at 3:00 PM, a Unit Manager, confirmed the length of R194's fingernails exceeded 0.25 inch and dark matter was present beneath multiple fingernails. The Unit Manager explained it was R194's choice to have the fingernails trimmed. The Unit Manager explained Certified Nursing Assistants (CNAs) where to check resident's fingernails during care and report to nurse if nails needed to be trimmed. The Unit Manager verbalized perhaps CNAs were not trimming R194's (continued on next page)		

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Form Approved OMB
No. 0938-0391

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 06/05/2026
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	finger nails because they thought the podiatrist would do it. The Unit Manager acknowledged R194's right middle fingernail was much shorter than the rest and explained it was possible the nail broke off. The Unit Manager acknowledged nail care including trimming and cleaning underneath the fingernails should have been provided to R194. A facility policy titled Fingernails/Toenails, undated, documented the purpose of the procedure was to clean the nail bed, to keep nails trimmed, and to prevent infections. Routine nail care may be performed by nursing staff and/or qualified activity team members. Nial care included daily cleaning and regular trimming.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure 1) enteral feeding bottle and hydration bag were labeled in accordance with facility policy for 1 of 64 sampled residents (Resident 245), and 2) a physician order was obtained for an enteral feeding tube de-clogging procedure for 1 of 64 sampled patients (Resident 5). The deficient practice placed the resident at risk for complications and for the resident's physician not to be aware of the enteral feeding tube clogging event and providing clinical oversight of the medical situation. Findings include: Resident 245 (R245) was admitted on [DATE] and readmitted on [DATE], with diagnoses including traumatic brain injury, encephalopathy, and attention for gastrostomy. The annual minimum data set (MDS) dated [DATE], revealed R245 received nutrition by enteral feeding. On 06/02/2026 at 9:42 AM, R245 laid supine in bed and was nonverbal. A tube feeding pump was infusing Peptamen 1.5 formula at 65 cubic centimeters (cc) per/hour (hr.). A Licensed Practical Nurse (LPN) confirmed the enteral formula was not labeled with the resident's name, date and time initiated, and the tubing and hydration bag was not labeled with date and time as well. The LPN indicated enteral formula, tubing and hydration bags must be labeled with date and time along with initials of the person who hung the set up. On 06/03/2026 at 1:33 PM, the Unit Manager indicated speaking with the night nurse who hung 245's enteral formula on the evening of 06/01/2026. According to the Unit Manager, the night nurse had intended to label and date the tube feeding set up after attending to another resident but had forgotten to do so. On 06/03/2026 at 1:39 PM, the Assistant Director of Nursing (ADON) confirmed the facility policy required enteral formulas to be labeled with resident's name, date and time started. The ADON indicated R245's formula was a closed system and was good for 24 hours once accessed. The facility's Enteral Feedings policy dated 10/01/2021, instructed to check the enteral nutrition against the order prior to administration. On the formula container, document initials, date and time the formula was hung. Practice strict adherence to maximum hang times, open systems have a maximum hang time of eight hours while closed systems have a maximum hang time of 24 hours. Resident 5 (R5) was initially admitted at the facility on 05/17/2022 with diagnoses including chronic respiratory failure and dysphagia oropharyngeal phase. On 06/04/2026 at 2:15 PM, observed R5 receiving tube feeding (TF) via an enteral feeding pump. The TF was connected to R5's gastrostomy (GT) tube. The nurse caring for R5 was at the bedside and confirmed having used a declogger device on R5's GT in the past. The nurse confirmed R5 has a tendency to clog up the GT wherein a declogger device had to be used to free up the clogged section of the GT. The nurse indicated seeing several sizes of the declogger device stocked by the facility. The nurse was not aware a physician order had to be obtained prior to performing a declogging GT procedure. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/2026 at 10:50AM, observed R5 bedside table had an opened cover sleeve of a declogger device. The nurse caring for R5 was not sure as to why the declogger device was there and stated the night nurse might have used it to unclog R5's GT. The nurse confirmed not being aware a physician order was needed to perform a GT declogging procedure. The nurse indicated training for the declogging procedure was obtained through other nurses. R5's physician orders lacked documented evidence of an order to declog the GT. On 06/04/2026 at 2:45 PM, the director of nursing (DON) was not aware the declogger device was being used in the facility. The DON indicated they would check if the facility had a policy and procedure for any enteral feeding tube declogging procedure. On 06/05/2026 at 11:00AM, the director of staff development (DSD) was not aware of nursing staff obtaining orders for declogging enteral feeding tubes. The DSD agreed there could have been risk in the procedure (examples included damage of the GT wall or perforation of the stomach lining). The DSD acknowledged all procedures for a resident, especially with potential risk should have a physician order. On 06/05/2026 at 11:10, the DON confirmed the facility did not have a policy and procedure for the enteral feeding declogging process. The DON confirmed orders should have been obtained and staff training should be offered to ensure resident safety during the procedure. Complaint 303420		