Acceptable POC
12/10/2025 BS



Nevada State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10962 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/22/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TLC CARE CENTER | 1500 W WARM SPRINGS RD , HENDERSON, Nevada, 89014 |

| (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 |
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| Z0000 | Initial Comments<br><br>This Statement of Deficiencies was generated as a result of a State Licensure Complaint investigation initiated in your facility on October 15, 2025, and finalized on October 22, 2025, in accordance with Nevada Administrative Code (NAC) 449, Skilled Nursing Facilities.<br><br>The census at the time of the survey was 234.<br><br>The sample size was 19<br><br>There were fifteen complaints, and three Facility Reported Incidents (FRIs) investigated.<br><br>1. Complaint 2280544: Deficient practice was identified (See Tag Z301).<br><br>2. Complaint 2280547: Deficient practice was identified (See Tag Z266).<br><br>3. Complaint 2280552: Deficient practice was identified (See Tag Z470).<br><br>4. Complaint 2280555: Deficient practice was identified (See Tag Z470).<br><br>5. Complaint 2280554: Deficient practice was identified (See Tag Z310).<br><br>6. Complaint 2563572: Deficient practice was identified (See Tag Z230).<br><br>7. Complaint 2639998: Deficient practice was identified (See Tag Z501).<br><br>8. Complaint 2280556: Deficient practice was not identified.<br><br>9. Complaint 2616353: Deficient practice was not identified.<br><br>10. Complaint 2579706: Deficient practice was not identified. | Z0000 | RECEIVED<br>NOV 19 2025<br>BUREAU OF HEALTHCARE QUALITY & COMPLIANCE<br>LAS VEGAS, NV | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Tracy Brantley | Administrator | 11/19/25 |

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| Z0000 | Continued from page 1<br><br>11. Complaint 2566260: Deficient practice was not identified.<br><br>12. Complaint 2594320: Deficient practice was not identified.<br><br>13. Complaint 2280542: Deficient practice was not identified.<br><br>14. Complaint 2280543: Deficient practice was not identified.<br><br>15. Complaint 2588975: Deficient practice was not identified.<br><br>16. FRI 2280524: Deficient practice was identified (See Tag Z301).<br><br>17. FRI 2280533: Deficient practice was identified (See Tag Z302).<br><br>18. FRI 2280535: Deficient practice was not identified.<br><br>The investigation included:<br><br>Observation included residents' rooms, shower rooms, kitchen, smoking areas, residents' appearance, staff to resident interactions, resident to resident interactions, call light response, and a tour of the facility.<br><br>Interviews were conducted with residents, certified nursing assistants, licensed nurses, environmental services staff, physician, nurse practitioner, firefighter, director of maintenance, director of environmental services, dietitian, case manager, unit manager, infection control nurse, social worker, staffing coordinator, wound care, director of staff development, director of nursing, administrator, and assistant administrator.<br><br>Clinical record review of 19 residents which included residents of concern.<br><br>Document review included facility policy and procedures, staffing schedule, training records, grievance log, resident council meeting minutes, and infection control surveillance.<br><br>The findings and conclusions of any investigation by the Division of Purchasing and Compliance shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that | Z0000 | | |

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| Z0000 | Continued from page 2<br>may be available to any party under applicable federal, state, or local laws.<br><br>The following regulatory deficiencies were identified. | Z0000 | | |
| Z230<br>SS = D | Standards of Care<br><br>CFR(s): NAC 449.74469<br><br>A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and document review, the facility failed to ensure 1) facility staff documented behavioral refusals, failed to notify the attending physician of significant behavioral changes regarding the refusal of care, and did not implement interventions in accordance with the resident's care plan, for 1 of 19 sampled residents (Resident 19) and 2) medications were administered as ordered for 1 of 19 sampled residents (Resident 8). The deficient practice had the potential for residents to not obtain therapeutic effect of the prescribed medication and residents not maintaining clean clothing, bed linens and room.<br><br>Findings include.<br><br>1) Resident19 (R19) was admitted on 06/16/2022, with diagnoses including malignant neoplasm of the bladder, urostomy, major depressive disorder, and urinary tract infection.<br><br>On 10/17/2025 at 10:25 AM, an environmental inspection was conducted in Room 308 with the Director of Maintenance. A strong urine odor was detected from the hallway, and the odor intensified upon entering the room.<br><br>R19 was observed in bed, covered with a white sheet that was visibly soiled with a large yellow stain resembling dried urine. The fitted sheet displayed similar staining. The floor surrounding the bed was wet with a yellowish liquid consistent with urine. R19 was found wearing visibly soiled, urine-soaked garments saturated with dried, urine-like fluid. The Director of Maintenance confirmed the observations and stated the | Z230 | 1. Resident #19 and #8 no longer reside at facility.<br><br>2. Any resident with behavioral refusals of care has the potential to be affected by the alleged deficient practice. Facility will audit 5 residents with behavioral refusals of care to ensure MD notification has been completed. Any issues identified will be corrected immediately.<br><br>Any resident receiving medications has the potential to be affected by the alleged deficient practice. Facility will randomly audit MARs for any meds not given to ensure MD notified. Any issues identified will be corrected immediately.<br><br>3.Licensed Nurses will be in-serviced regarding notification of physician for refusals of care or when meds are unavailable.<br><br>4. Facility will randomly audit 5 residents weekly x 4 and then monthly x 3 or until substantial compliance has been achieved ensure MD notification for refusals or meds not administered. Any issues identified will be corrected immediately. Findings will be submitted to QAPI.<br><br>5. Responsible Person: DON<br><br>6. Date of Completion: 11/28/25 | |

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| Z230 SS = D | Continued from page 3<br>room had recently undergone deep cleaning.<br><br>On 10/17/2025 at 10:30 AM, a Licensed Practical Nurse (LPN) who had provided care to R19 reported receiving the resident in this condition at the beginning of the shift around 6:30 AM. The LPN stated a verbal report from the night shift indicated R19 had been combative and refused hygiene care. The LPN notified the assigned Certified Nursing Assistant (CNA) that R19 required cleaning and a change of clothing. The CNA responded that R19 continued to refuse care and would not allow hygiene to be performed. The LPN acknowledged not notifying the attending physician and recognized the resident's condition was unacceptable and required immediate attention.<br><br>On 10/17/2025 at 10:35 AM, the CNA assigned to R19 confirmed the resident was received in urine-soaked clothing and refused all hygiene interventions, including showering, bed linen changes, and clothing changes. The CNA stated the LPN was aware of the situation.<br><br>On 10/17/2025 at 10:45 AM, the Director of Nursing (DON) was informed and confirmed the observations. The DON stated the resident's condition was unacceptable and unjustified. The DON explained when a resident refused care and exhibited behaviors such as urinating in bed and on clothing, the attending physician should be notified to consider psychiatric consultation. The DON emphasized such behaviors must be addressed, as they pose a health risk for the residents.<br><br>Review of the Activities of Daily Living (ADL) records for September and October 2025 indicated R19 was generally continent of bladder with intermittent incontinence and required setup assistance or was independent with toileting hygiene. The records showed R19 was scheduled for showers on Mondays, Thursdays, and as needed during the morning shift. Documentation revealed R19 refused all scheduled showers during this period, receiving only two bed/towel baths on 09/29/2025 and 10/06/2025.<br><br>The Minimum Data Set (MDS) Quarterly Assessment dated 07/06/2025 documented R19 had a urinary catheter and required setup or clean-up assistance for personal hygiene, performing the task independently once prepared. The assessment indicated R19 required supervision or touching assistance for toileting hygiene. Section E of the MDS noted R19 rejected care on 1 to 3 days during the 7-day look-back period.<br><br>A Physician Order dated 12/19/2023 instructed staff to | Z230 | | |

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| Z230 SS = D | Continued from page 4<br>monitor R19 for behaviors related to non-compliance with care on every shift.<br><br>A Care Plan for urinary continence dated 11/18/2024 and last revised on 07/29/2025 documented R19 was continent of bladder. The goal of the plan was to maintain cleanliness and dryness, with interventions including monitoring for signs of urinary tract infection and assisting with toileting.<br><br>A Behavioral Care Plan dated 12/03/2024 and last revised on 05/30/2025 identified behaviors such as refusal of showers, suprapubic care, and clothing changes. Interventions included psychiatric services and social services follow-up as needed.<br><br>The Medication Administration Record (MAR) for October 2025 indicated that R19 did not exhibit any behaviors associated with care refusal, including shower refusal, yelling, cursing, or hitting.<br><br>A Psychiatric Evaluation dated 04/10/2024 listed major depressive disorder as the only psychiatric diagnosis. The evaluation recommended continued administration of antidepressant medication and advised staff to contact the psychiatrist about urgent needs or changes in condition.<br><br>The medical record lacked documented evidence that the attending physician was made aware of the increased behaviors R4 was exhibiting regarding refusal of care.<br><br>2) Resident 8 (R8) was admitted on 04/25/2025 and discharged on 04/30/2025 with diagnoses including hepatic encephalopathy, respiratory failure and ulcerative colitis.<br><br>A Physician Order dated 04/25/2025 documented Rifaximin (an antibiotic used to treat and prevent hepatic encephalopathy) 550 milligrams (mg) give one tablet by mouth two times a day.<br><br>The Medication Administration Record (MAR) for April 2025 documented a nine to indicate "other" for the following dates/times:<br><br>-04/26/2025 at 8:00 AM and 8:00 PM<br><br>-04/28/2025 at 8:00 PM<br><br>-04/29/2025 at 8:00 PM<br><br>The MAR administration notes documented the following: | Z230 | | |

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| Z230 SS = D | Continued from page 5<br>-04/26/2025 at 7:55 AM, Rifaximin on order from pharmacy.<br><br>-04/26/2025 at 8:06 PM, Rifaximin awaiting order.<br><br>-04/28/2025 at 7:11 PM, Rifaximin awaiting order.<br><br>-04/29/2025 at 9:23 PM, Rifaximin not available.<br><br>On 10/17/2025 at 7:42 AM, a Licensed Practical Nurse (LPN) explained when needing to order medications the orders were sent to the pharmacy, if the medication was not available for administration would contact the pharmacy to determine the status of the medication, depending on the pharmacy response such as the medication not available would then alert the physician.<br><br>On 10/17/2025 at 10:42 AM, the Director of Nursing (DON) explained when a resident's medication was not available for administration the expectation would be for the nurse to call the pharmacy to determine the status of the medication. If the medication was not available for administration the staff were to notify the physician. The DON explained notification to the physician was a standard of practice and was unaware if the facility had a policy regarding notifying the physician when medication was not available for administration. The DON reviewed R8's medical record and confirmed that Rifaximin was not administered as ordered and the record lacked documented evidence the physician was notified.<br><br>Severity: 2 Scope: 1<br><br>Complaint 2280547 | Z230 | | |
| Z266 SS = D | Pressure Sores<br><br>CFR(s): NAC 449.74477<br><br>Based on the comprehensive assessment of a patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shell ensure that a patient:<br><br>2. With pressure sore receives the services and treatment needed to promote healing, prevent infection and prevent new sores from developing.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview, record review, and document review, the facility failed to provide documented evidence an order for wound care treatments was obtained and | Z266 | 1. Resident #8 no longer resides in facility.<br><br>2. Any resident with wounds has the potential to be affected by the alleged deficient practice. Facility will audit other residents with wounds to ensure orders are in place.<br><br>3. Wound nurses will be in-serviced regarding protocol to obtain orders for wound care for any resident with wounds. | |

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| Z266 SS = D | Continued from page 6<br>provided for 1 of 19 sampled residents (Resident 8). The deficient practice had the potential to place the resident at risk for delayed healing of a wound.<br><br>Findings include:<br><br>Resident 8 (R8) was admitted on 04/25/2025 and discharged on 04/30/2025 with diagnoses including hepatic encephalopathy, respiratory failure, and ulcerative colitis.<br><br>A Physician Order dated 04/25/2025 documented wound care evaluation and treat as indicated.<br><br>A Skin/Wound Note dated 04/26/2025 documented initial admission skin assessment completed by wound care nurse. R8 had a wound in the sacrum area with clean and dry Opti foam dressing applied over the area.<br><br>A facility document titled Admission Report Sheet dated 04/25/2025 documented skin integrity/wounds with location: pressure injury stage 2 coccyx.<br><br>R8's medical record lacked physician orders for wound care treatments.<br><br>On 10/16/2025 at 1:01 PM, a Wound Care Nurse explained upon admission of a resident or within 24 hours a member of the wound care team would assess the resident's skin and document the findings. The Wound Care Nurse would obtain necessary treatment orders if the resident required wound care. The Wound Care Nurse reviewed R8's medical record and confirmed R8 was admitted with a pressure injury and R8's medical record lacked a physician order wound care treatment.<br><br>The facility policy titled "Pressure Injury/Skin Breakdown- Clinical Protocol", undated, documented obtain physician order for preventative skin care including appropriate treatments for existing pressure ulcers.<br><br>Severity: 2 Scope: 1<br><br>Complaint 2280547 | Z266 | 4. DON or designee will randomly audit 5 residents weekly x 4 and then monthly x 3 or until substantial compliance has been achieved to ensure orders for wound care are in place. Any issues identified will be corrected immediately. Findings will be submitted to QAPI.<br><br>5. Responsible Person: DON<br><br>6. Date of Completion: 11/285/25 | |
| Z301 SS = D | Prohibited practices<br><br>CFR(s): NAC 449.74491<br><br>2. A facility for skilled nursing shall adopt procedures which ensure that all alleged violations of the policies adopted pursuant to subsection 1 and injuries to patients of unknown origin are reported | Z301 | | |

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| Z301 SS = D | Continued from page 7<br>immediately to the administrator of the facility, to the bureau and to other officials in accordance with state law, and are thoroughly investigated. The procedures must ensure that further violations are prevented while the investigation is being conducted.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview, record review and document review, the facility failed to ensure 1) alleged incident of verbal abuse was investigated for 2 of 19 sampled residents (Residents 12 and 13) and 2) an injury of unknown origin was investigated and reported to the State Agency (SA) for 1 of 19 sampled residents (Resident 7). The deficient practice had the potential to compromise the safety and well-being of residents.<br><br>Findings include:<br><br>1) Resident 12 (R12) was admitted to the facility on 02/24/2025 and discharged on 04/01/2025 with diagnoses including non-pressure chronic ulcer of left foot, difficulty in walking and type 2 diabetes mellitus.<br><br>Resident 13 (R13) admitted on 01/22/2025 and discharged on 03/21/2025 with diagnoses including urinary tract infection, difficulty in walking and hypertension.<br><br>An initial Facility Reported Incident (FRI) was submitted to the SA on 03/18/2025 at 8:08 PM by the Assistant Administrator documenting a staff member's alleged verbal abuse on 03/18/2025 at 6:30 PM. No final report was received by the SA.<br><br>R12 and R13's medical record lacked documentation regarding the alleged event.<br><br>On 10/16/2025 at 2:06 PM, the Assistant Administrator explained during the time of the alleged event, the Assistant Administrator had assisted with submitting the initial report to the SA. Another employee, who was no longer employed at the facility, was completing the investigation and final report. The Assistant Administrator was unaware of the findings of the investigation and if the staff member was suspended pending the investigation.<br><br>The facility employee file for the alleged staff member lacked documented evidence of a suspension.<br><br>2. Resident 7 (R7) was admitted on 01/27/2020 with diagnoses including chronic obstructive pulmonary disease, muscle weakness, and type 2 diabetes mellitus. | Z301 | 1. Resident #12 and #13 no longer reside at facility. Resident #7 has had no negative outcome related to alleged deficient practice and the injury of unknown was reported to the SA at the time of survey.<br>The final report for residents #12 and #13 have been submitted to the SA.<br><br>2. Any resident with allegation of abuse has the potential to be affected by the alleged deficient practice. All allegations brought to the facilities attention have been reported to the SA at this time.<br><br>3. Assistant Administrator will be in-serviced on requirement for timely completion of self-reports to the SA.<br><br>4. Administrator will audit allegations of abuse/neglect weekly x 4 and then monthly x 3 or until substantial compliance has been achieved to ensure allegations have been reported to SA per regulatory requirements. Any issues identified will be corrected immediately. Findings will be submitted to QAPI committee.<br><br>Responsible Party: Administrator<br><br>Date of Completion: 11/28/25 | |

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| Z301 SS = D | Continued from page 8<br>A Progress Note dated 04/29/2025 documented weekly skin observation completed. Bruise to right arm. Bruising to right arm fading.<br><br>R7's medical record lacked documentation regarding the injury of unknown origin.<br><br>On 10/16/2025 at 10:32 AM, R7 explained remembering having a bruise to the arm and explained was unsure how it occurred.<br><br>On 10/16/2025 at 11:35 AM, the Assistant Administrator and the Administrator were unaware of the alleged event and an investigation had not been conducted.<br><br>On 10/16/2025 at 1:23 PM, a Social Worker Supervisor with Aging and Disability explained the department became aware of the alleged event for R7 via a web-based facility notification for a report of abuse.<br><br>On 10/16/2025 at 2:15PM, the Administrator/Abuse Coordinator explained the process for alleged abuse/neglect and injury of unknown origin was for the facility to file a report with Aging and Disability, the SA, and Ombudsman. If aware of any known perpetrator and it was a staff member the individual was to be suspended pending the investigation to ensure safety for all residents. The Administrator explained an investigation would be conducted to include interviews with staff and residents. The Administrator explained an assessment of the resident was to be performed to assess for any signs/symptoms of injury.<br><br>The facility policy titled "Abuse", dated 10/01/2021, documented the organization recognizes and respects each resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation. The organization will maintain systems to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but no later than 2 hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or designee, and to other officials (including State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Designated staff will immediately review and investigate allegations or observations of abuse. | Z301 | | |

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| Z301 SS = D | Continued from page 9<br><br>Severity: 2 Scope: 1<br><br>Complaint 2280544<br><br>Facility Reported Incident 2280533, 2280524 | Z301 | | |
| Z302 SS = D | Prohibited practices<br><br>CFR(s): NAC 449.74491<br><br>3. The results of any investigation must be reported:<br><br>a) To the administrator of the facility or his designated representative and to the bureau within 5 working days after the alleged violation is reported.<br><br>b) In the manner prescribed in NRS 200.5093 and 432B.220 and chapter 433 of NRS.<br><br>The administrator of the facility shall take appropriate action to correct any violation.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview, record review and document review, the facility failed to ensure an alleged incident of verbal abuse was reported to the State Agency (SA) within the required timeframes for 3 of 19 sampled residents (Residents 6, 12 and 13). The deficient practice had the potential to place residents at risk for incidents of verbal abuse to not be adequately protected.<br><br>Findings include:<br><br>Resident 6 R6 was originally administered on 03/13/2021 and re-admitted on 09/11/2024, with diagnoses including dementia.<br><br>Resident 5 R5 was originally admitted on 11/18/2019, with diagnoses including history of Tourette's, developmental delay and psychosis.<br><br>An initial incident report transmitted to the SA, revealed on 02/24/2025 around 10:30 AM, a Certified Nursing Assistant (CNA) witnessed R5 hitting R6 in the face and shaking their shoulder in the 200 hall of the facility. R6 was assessed by a nurse and no signs of harm were identified. The Police Department was called, and an officer interviewed both residents. R6 refused to press charges against R5. The residents were separated, and emergency contacts were notified, as well as facilities Medical Director, Director of | Z302 | 1. Residents #6, #12, and #13 no longer reside in facility.<br>The final report for resident #6 has been submitted to the SA.<br><br>2. Any resident with allegation of abuse has the potential to be affected by the alleged deficient practice. All allegations brought to the facilities attention have been reported to the SA at this time.<br><br>3. Assistant Administrator will be in-serviced on requirement for timely completion of self reports to the SA.<br><br>4. Administrator will audit allegations of abuse/neglect for 3 months or until substantial compliance has been achieved to ensure they have been reported to the SA per regulatory requirements. Findings will be submitted to QAPI Committee.<br><br>Responsible Person: Administrator<br><br>Date of Completion: 11/28/25 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10962 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/22/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| TLC CARE CENTER | 1500 W WARM SPRINGS RD , HENDERSON, Nevada, 89014 |

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| Z302 SS = D | Continued from page 10<br>Nursing (DON), and administrators in training (AITs). The report documented the facility's Administrator was in the process of conducting their own investigation.<br><br>On 10/17/2025 at 11:30 AM, the Assistant Administrator explained a gap in administration occurred at that time of the incident and the investigation seemed to not being conducted. The facility could not produce a final report or provide evidence that an investigation was conducted.<br><br>Resident 12 (R12) was admitted to the facility on 02/24/2025 and discharged on 04/01/2025 with diagnoses including non-pressure chronic ulcer of left foot, difficulty in walking and type 2 diabetes mellitus.<br><br>Resident 13 (R13) admitted on 01/22/2025 and discharged on 03/21/2025 with diagnoses including urinary tract infection, difficulty in walking and hypertension.<br><br>An initial Facility Reported Incident (FRI) was submitted to the SA on 03/18/2025 at 8:08 PM by the Assistant Administrator documenting a staff member's alleged verbal abuse on 03/18/2025 at 6:30 PM. No final report was received by the SA.<br><br>R12 and R13's medical record lacked documentation regarding the alleged event.<br><br>On 10/16/2025 at 2:06 PM, the Assistant Administrator explained during the time of the alleged event, the Assistant Administrator had assisted with submitting the initial report to the SA. Another employee, who was no longer employed at the facility, was completing the investigation and final report. The Assistant Administrator was unaware of the findings of the investigation and if the staff member was suspended pending the investigation.<br><br>On 10/16/2025 at 2:15 PM, the Administrator/Abuse Coordinator explained the process for alleged abuse events was once the investigation was completed the finding would be submitted in a final report to all agencies regarding the findings, the report would be made within 5 days. The Administrator explained the resident care plan would be updated to reflect events.<br><br>The facility policy titled "Abuse", dated 10/01/2021, documented the results of all investigations are to be communicated to the administrator or designated representative and to other officials in accordance with State law, including State Survey Agency, within five working days of the incident. | Z302 | | |

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| Z302 SS = D | Continued from page 11<br>Severity: 2 Scope: 1<br><br>Facility Reported Incident 2280533 | Z302 | | |
| Z310 SS = D | Notification of Changes or Condition<br><br>CFR(s): NAC449.74493<br><br>1. A facility for skilled nursing shall immediately notify a patient, the patient's legal representative or an interested member of the patient's family, if known, and, if appropriate, the patient's physician, when:<br><br>(a) The patient has been injured in an accident and may require treatment from a physician;<br><br>(b) The patient's physical, mental or psychosocial health has deteriorated and resulted in medical complications or is threatening the patient's life;<br><br>(c) There is a need to discontinue the current treatment of the patient because of adverse consequences caused by that treatment or to commence a new type of treatment;<br><br>(d) The patient will be transferred or discharged from the facility;<br><br>(e) The patient will be assigned to another room or assigned a new roommate; or<br><br>(f) There is any change in federal or state law that affects the rights of the patient.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and document review, the facility failed to notify the physician regarding the inability to perform a biliary catheter flush for 1 of 19 sampled residents (Resident 16). The deficient practice had the potential to pose a risk of infection, catheter obstruction, and complications.<br><br>Findings Include:<br><br>Resident 16 (R16) was admitted to the facility on 03/23/2025, with diagnoses including spastic diplegic cerebral palsy, dysphagia, schizoaffective disorder, and depression.<br><br>The Physician Order Summary documented a standing order to flush the biliary drain with 10 cubic centimeters (cc) of normal saline each shift (between 6 AM–6 PM and 6 PM–6 AM). | Z310 | 1. Resident #16 biliary drain is being flushed per MD orders and has had no negative outcome related to alleged deficient practice.<br><br>2. Any resident with a biliary drain has the potential to be affected by the alleged deficient practice. None have been identified.<br><br>3. Licensed Nurses will be in-serviced regarding protocol for flushing the biliary drain or notifying the physician if unable to flush the drain.<br><br>4. DON or designee will audit weekly x 4 and then monthly x 3 or until substantial compliance has been achieved to ensure the drain is being flushed. Any issues identified will be corrected immediately. Findings will be given to the QAPI Committee.<br><br>Responsible Party: DON<br><br>Date of Completion: 11/28/25 | |

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| Z310 SS = D | Continued from page 12<br><br>The Progress Notes dated 10/02/2025 documented the same flushing order.<br><br>The Medication Administration Record (MAR) from 09/01/2025 to 09/30/2025 and from 10/01/2025 to 10/16/2025 included entries marked with the number "9," indicating the flush was not completed. The electronic MAR noted "not able," "unable," or "difficult" to flush on 10/05/2025, 10/06/2025, and 10/11/2025.<br><br>On 10/17/2025 at 8:00 AM, a Licensed Practical Nurse (LPN) stated that the biliary catheter was flushed daily. When the catheter was flushed it was typically dry with no output. The LPN expressed uncertainty about the purpose of the flushing and reported attempting to obtain clearer guidance on the procedure.<br><br>On 10/17/2025 at 8:15 AM, R16 reported the biliary catheter was flushed once a week and that staff performed the flush.<br><br>On 10/17/2025 at 8:30 AM, the Unit Manager stated the biliary catheter was not under wound care services and was flushed by nursing staff. The Unit Manager explained the proper procedure for flushing the catheter: clean the port with an alcohol wipe, use gloves, attach a syringe to the needleless connector, and flush with normal saline. The Unit Manager indicated that all nursing staff should be trained in this procedure. It was noted that on the medication administration record (MAR), a checkmark indicates the flush was performed, while the number "9" signified it was not. The Unit Manager stated that if biliary catheter flushing could not be performed, the nurse must notify thephysician.<br><br>On 10/17/2025 at 2:45 PM, the Director of Nursing (DON) indicated biliary catheter flushes must be performed according to physician orders. If the nurse was unable to flush the catheter or encountered difficulty, the physician must be notified. The DON revealed there was no documentation of standard procedures, training records, or policy related to biliary catheter flushes.<br><br>On 10/17/2025 at 2:45 PM, the Infection Preventionist (IP) confirmed nurses must follow physician orders when performing the biliary catheter flush. The IP emphasized that if the flush was not performed, the physician should be notified immediately.<br><br>Severity: 2 Scope: 1<br><br>Complaint 2563572 | Z310 | | |

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| Z310 Z452 SS = D | Radiological and Other Diagnostic Services<br><br>CFR(s): NAC 449.74535<br><br>3. A facility for skilled nursing shall:<br><br>(a) Provide or obtain only such radiological and other diagnostic tests as are ordered by the attending physician of a patient in the facility;<br><br>(b) Promptly notify the attending physician of the results of those tests;<br><br>(c) Arrange transportation for a patient to obtain radiological and other diagnostic tests ordered by the patient's attending physician, if the patient requires such assistance; and<br><br>(d) Include in the medical records of a patient all reports of the results of radiological and other diagnostic tests ordered for the patient. The report must:<br><br>(1) Include the date on which the tests were performed; and<br><br>(2) Be signed by the person performing the tests.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on the interview, document review, and record review, the facility did not notify the physician of a diagnostic result (abdominal ultrasound for ascites) for 1 of 19 residents (Resident 15). This deficient practice had the potential for delayed medical intervention.<br><br>Findings Include:<br><br>Resident 15 (R15) was admitted to the facility on 05/19/2025 and discharged on 05/27/2025, with diagnoses including a displaced intertrochanteric fracture of the right femur, cirrhosis of the liver, and type 2 diabetes mellitus.<br><br>A Physician Order Summary dated 05/23/2025 documented an abdominal ultrasound (B-scan and/or real-time with imaging) was ordered via phone due to elevated liver transaminase levels, in relation to suspected ascites.<br><br>Progress Notes from the Initial History and Physical, dated 05/21/2025, included ascites as part of the treatment plan. | Z310 Z452 | 1. Resident #15 no longer resides in facility.<br><br>2. Residents requiring radiological testing have the potential to be affected by the alleged deficient practice. Facility has audited current residents with radiology orders and all have been reported to MD.<br><br>3. Licensed Nurses will be in-serviced on the protocol to notify MD of radiology results.<br><br>4. DON or designee will randomly audit 5 residents weekly x 4 and then monthly x 3 or until substantial compliance has been achieved to ensure that radiology results are reported to MD. Any issues identified will be corrected immediately. Findings will be submitted to QAPI Committee.<br><br>Responsible Person: DON<br><br>Date of Completion: 11/28/25 | |

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| Z452<br>SS = D | Continued from page 14<br>The Radiology Report documented the presence of asciles in all quadrants of the abdomen, with a total volume measured at 3.0 liters.<br><br>On 10/16/2025 at 2:30 PM, the Unit Manager stated there was no documentation nurses had contacted the physician regarding the radiology result.<br><br>On 10/17/2025 at 9:30 AM, the Unit Manager confirmed there was no documentation showing any action taken after receiving the radiology results. The Unit Manager stated the nurses should have notified the physician of the results of the ultrasound.<br><br>On 10/17/2025 at 2:00 PM, the Advanced Practice Registered Nurse (APRN) stated they did not receive notification from the facility regarding R15's radiology result, which documented 3.0 liters of asciles.<br><br>On 10/17/2025 at 3:30 PM, the Physician stated there was no communication from the facility regarding the radiology result for R15. The Physician emphasized failure to report such findings could result in pain, shortness of breath, and pressure on the lungs, and that immediate medical intervention was necessary due to the volume of fluid.<br><br>The facility's policy titled "Change in a Resident's Condition" (undated) documented nurses must notify the attending physician/practitioner (or the physician on call) when there are specific instructions or when there is a change in the resident's condition. Before notification, the nurse is responsible for making detailed observations and gathering all relevant information for the provider.<br><br>Severity: 2 Scope: 1<br><br>Complaint 2280554 | Z452 | | |
| Z470<br>SS = E | Physical Environment<br><br>CFR(s): NAC 449.74539<br><br>1. Provide a safe, functional, sanitary and comfortable environment for the patients in the facility, the members of its staff and members of the general public.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to maintain a clean, sanitary, and comfortable environment for residents in 11 of 11 rooms | Z470 | | |

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| Z470 SS = E | Continued from page 15<br>observed (Rooms 303, Shower Room, 307, 309, 310, 311, 312, 314, 412, 415, and 415 air conditioning unit). The deficient practice had the potential for the facility to not maintain a clean environment.<br><br>Findings included:<br><br>On 10/15/2025 in the morning, environmental observations were conducted in the 300 Hall accompanied by the Director of Nursing (DON). During a walkthrough of the 300 Hall, the following environmental concerns were identified:<br><br>Shower Room adjacent to Room 306: The toilet located within the shower room was visibly soiled with a brownish substance resembling fecal matter. The condition of the toilet indicated that it had not been recently or adequately cleaned.<br><br>Room 303: A viscous, black-colored substance with embedded particulate debris was observed along the seam where the baseboard meets the floor. The material appeared sticky and had accumulated over time. The baseboard on the wall directly across from the residents' beds was deteriorating and partially detached from the wall surface.<br><br>A resident, occupying the bed closest to the door, reported that housekeeping staff refrained from using chemical cleaning agents in the room at the resident's request, due to respiratory sensitivities.<br><br>Room 307: A sticky black residue was present along the baseboard-floor junction. In the left-hand corner near the room entrance debris was observed. The area was visibly soiled with a brownish-yellowish sticky substance. The floor in this section of the room was visibly dirty.<br><br>Room 309: A dark, sticky residue, ranging in color from black to brownish, was observed along the perimeter where the baseboards meet the flooring. A resident residing in this room expressed concern regarding the lack of cleanliness, specifically noting that the persistent presence of the sticky residue was disturbing and unsanitary.<br><br>The resident reported the existence of a visible gap between the air conditioning unit and the wall where the unit was installed. The gap had allowed rainwater and insects to enter the room, contributing to environmental discomfort and potential hygiene issues.<br><br>Rooms 310, 311, 312, and 314: Each of these rooms | Z470 | 1. No specific residents were cited as being affected by the alleged deficient practice.<br><br>2. The toilet in the shower room adjacent to room 306 has been replaced.<br><br>Regarding the flooring in rooms 303, 307, 309, 310, 311, 312, and 314 the facility has mopped all rooms and has hired a vendor to replace all flooring in the 300 hall as it is worn beyond routine cleaning.<br><br>Room 307 brownish-yellowish stick substance has been removed.<br><br>Room 309 the gap between air conditioner and wall has been repaired.<br><br>Room 415 floor was cleaned, and underwear were removed from the top of the air conditioner at the time of survey. Room 412 floor was cleaned at the time of survey.<br><br>3. Housekeeping staff will be in-serviced regarding cleaning protocols for resident room.<br><br>EVS Director will place a mop and broom in each clean utility room to allow after hours cleaning of spills as necessary.<br><br>4. EVS Director/Designee will randomly audit weekly x 4 and then monthly x 3 or until substantial compliance has been achieved to ensure resident rooms/floors are clean. Any issues identified will be corrected immediately. Findings will be submitted to QAPI Committee.<br><br>Person Responsible: EVS Director<br><br>Date of Completion: 11/28/2025 | |

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| Z470 SS = E | Continued from page 16<br>exhibited consistent presence of a dark, sticky residue ranging in color from black to brownish along the perimeter where the baseboards meet the flooring.<br><br>The Director of Nursing confirmed these observations and acknowledged that these areas should have been properly cleaned as part of routine housekeeping protocols.<br><br>On 10/17/2025 at 11:00 AM, the Director of Maintenance explained the sticky dark matter was the result of the use of wax that with the time had been accumulated.<br><br>On 10/15/2025 at 7:58 AM, in room 415 the floor at the foot of the bed had three areas of dried substances visible from the hallway. One area of dark brown, one area of light brown, and one large area of a red substance was partially covered with a white towel.<br><br>On 10/15/2025 at 8:00 AM, a Certified Nurse Assistant (CNA) explained arrived at 6:00 AM and was unsure how long the substances had been on the floor, verbalized it was like that when arrived, so probably from night shift. The CNA explained there were no housekeeping services at night and was unaware if staff had access to a mop.<br><br>On 10/15/2025 at 8:03 AM, upon entry into room 412, a foul odor was noted, and the floor surface was sticky to the extent shoes adhered to the floor while walking. The floor around the resident bed had visible areas of dried and wet substance brownish in color. The bed was without sheets, and the mattress had areas of feces smeared near the foot of the mattress. A blanket was balled up lying in the corner of the room opposite the bed. Upon entry into the bathroom a soiled brief was lying on the floor next to the trash can, the toilet seat had areas of dried feces smeared across the seat, and feces soiled brief was lying on the floor in front of the toilet.<br><br>On 10/15/2025 at 8:10 AM, the Administrator confirmed the findings, and explained housekeeping cleaned the rooms daily however the soiled items should have been removed by staff.<br><br>On 10/15/2025 at 8:14 AM, upon entry into room 415 lying on top of the air conditioning wall unit was a pair of light blue underwear with yellow stains with a brown stained panty liner.<br><br>On 10/15/2025 at 8:16AM, the Administrator confirmed the findings in room 415 and explained housekeeping services needed to be contacted. | Z470 | | |

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| Z470 SS = E | Continued from page 17<br><br>The facility policy titled "Cleaning and Disinfecting Environmental Surfaces", dated 10/01/2021, documented housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when the surfaces are visibly soiled. Spills of blood and other potentially infectious material will promptly be cleaned and decontaminated.<br><br>Severity: 2 Scope: 2<br><br>Complaint 2280552, 228055, and 2280554 | Z470 | | |
| Z472 SS = D | Physical Environment<br><br>CFR(s): NAC 449.74539<br><br>3. Ensure that the environment of the facility is free of hazards that would cause accidents;<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and document review the facility failed to ensure chemicals were securely stored and inaccessible to residents. The deficient practice had the potential for accidental exposure or ingestion of a harmful substance.<br><br>Findings include:<br><br>On 10/15/2025 at 8:03 AM, on a metal shelf located on the wall in the bathroom of room 412 was a white spray bottle labeled "Buff and Scuff Remover".<br><br>On 10/15/2025 at 8:10 AM, the Administrator acknowledged the spray bottle in room 412 and explained chemicals should not have been left accessible to residents.<br><br>On 10/16/2025 at 2:05 PM, the Assistant Administrator explained "Buff and Scuff Remover" was used when staff buff the floors.<br><br>On 10/17/2025 at 7:55 AM, the Environmental Service Director explained cleaning chemicals were to remain locked and inaccessible when not in use. The Environmental Service Director explained that the buff and scuff product was a waxing product used when waxing floors and the product was to be kept secure when not in use.<br><br>The facility Safety Data Sheet for spray Buff and Scuff Remover, dated 10/21/2024, documented the mixture consisted of ingredient(s) of unknown toxicity. Avoid | Z472 | 1. No residents were identified as being affected by the alleged deficient practice.<br><br>2. Any resident has the potential to be affected by the alleged deficient practice. None have been identified as being affected.<br><br>3. Housekeeping staff will be in-serviced regarding the protocol to properly store chemicals when not in use.<br><br>4. EVS Director will randomly audit weekly x 4 and then monthly x 3 or until substantial compliance has been achieved to ensure no chemicals are left out or not properly stored. Any issues identified will be corrected immediately. Findings will be given to QAPI Committee.<br><br>Responsible Person: EVS Director<br><br>Date of Completion: 11/28/25 | |

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| Z472 SS = D | Continued from page 18<br>contact with eyes and skin. Do not taste or swallow.<br><br>Severity: 2 Scope: 1 | Z472 | A. No residents were identified as being affected by the alleged deficient practice<br>1. The "TBL D/D 200 Wing" alarm was cleared after the corresponding HVAC unit power was restored.<br><br>The vendor tested the nine smoke detectors on 10/22/25 and all passed<br><br>2. The AHU-C1 duct detector code has been cleared<br><br>3. The 9 smoke detectors were tested by the vendor on 10/22/2025 and all passed<br><br>4. If smoke detectors are found to be not operating correctly, the facility will have vendor find an appropriate refurbished replacement and then have the sensitivity testing completed to show they meet requirements of existing system<br><br>B. No residents were identified as being affected by the alleged deficient practice<br><br>1. The dry sprinkler system has been repaired and put back into full service as of 10/31/2025. Rooms #607 and #6098 have been patched and repaired.<br><br>2. The vendor has been onsite and pulled a sampling of the QR wet and dry sprinkler heads to send out for testing. Facility will follow testing recommendations to either keep in service or replace<br><br>3. The vendor has been onsite and pulled a sampling of the QR wet and dry sprinkler heads to send out for testing. Facility will follow testing recommendations to either keep in service or replace | |
| Z501 SS = F | Compliance with NFPA 101<br><br>CFR(s): NAC 449.74543.2(a)<br><br>2. Except as otherwise provided in this section:<br><br>(a) A facility for skilled nursing shall comply with the provisions of the NFPA 101: Life Safety Code, adopted by reference pursuant to section 2 of this regulation.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>CODE PATH:<br><br>National Fire Protection Association (NFPA) 101 Life Safety Code, 2024 Edition<br><br>3.2 NFPA Official Definitions<br><br>3.2.1 Approved. Acceptable to the authority having jurisdiction.<br><br>4.5.2 Appropriateness of Safeguards. Every building or structure shall be provided with means of egress and other fire and life safety safeguards of the kinds, numbers, locations, and capacities appropriate to the individual building or structure, with due regard to the following:<br><br>(1) Character of the occupancy, including fire load<br><br>(2) Capabilities of the occupants<br><br>(3) Number of persons exposed<br><br>(4) Fire protection available<br><br>(5) Capabilities of response personnel<br><br>(6) Height and construction type of the building or structure<br><br>(7) Other factors necessary to provide occupants with a reasonable degree of safety<br><br>4.5.8 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any feature is required for compliance | Z501 | | |

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| Z501 SS = F | Continued from page 19<br>with the provisions of this code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained, unless the code exempts such maintenance.<br><br>4.6.1.1 The authority having jurisdiction (AHJ) shall determine whether the provisions of this code are met.<br><br>4.6.1.2 Any requirements that are essential for the safety of building occupants and that are not specifically provided for by this code shall be determined by the authority having jurisdiction.<br><br>4.6.1.3 Where it is evident that a reasonable degree of safety is provided, any requirement shall be permitted to be modified if, in the judgement of the authority having jurisdiction, its application would be hazardous under normal occupancy conditions.<br><br>9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70 National Electrical Code 2011 Edition and NFPA 72 Fire Alarm and Signaling Code 2010 Edition.<br><br>19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 9.7.<br><br>9.7.6 Sprinkler System Impairments. Sprinkler impairment procedures shall comply with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.<br><br>Appendix 9.6.1.6. A fire watch should at least involve some special action beyond normal staffing, such as assigning an additional security guard(s) to walk the areas affected. Such individuals should be specifically trained in fire prevention and in occupant and fire department notification techniques, and they should understand the particular fire safety situation for public education purposes.<br><br>Appendix 9.7.6. Where a fire watch is provided to meet the impairment requirements of NFPA 25, it is the intent of the Code that the fire watch results in a heightened awareness of the building's operations and environment. Individuals assigned to the fire watch should be able to recognize fire hazards and understand the procedures for occupants and fire department procedures for occupants and fire department notification and occupant evacuation in an emergency.<br><br>National Fire Protection Association (NFPA) 25 | Z501 | 4. The vendor has been onsite and pulled a sampling of the QR wet and dry sprinkler heads to send out for testing. Facility will follow testing recommendations to either keep in service or replace<br><br>5. The vendor has been onsite and pulled a sampling of the of the QR wet and dry sprinkler heads to send out for testing. Facility will follow testing recommendations to either keep in service or replace<br><br>C. No residents were identified as being affected by the alleged deficient practice<br><br>1. The facility has updated the Fire Watch policy to include the functions of the person conducting the Fire Watch<br><br>Staff conducting the Fire Watch have been in-serviced on procedure<br><br>D. No residents have been identified as being affected by the alleged deficient practice.<br><br>1. The oxygen cylinder cart was removed from the 200 hall oxygen room at the time of survey.<br><br>Maintenance Director has replaced the lock on the 600 hall oxygen storage room.<br><br>Staff has been in-serviced regarding not propping open the door to the oxygen storage rooms.<br><br>2. The facility has ordered signs that state, "Caution: Oxidizing Gas(es) Stored Within No Smoking" and will replace the existing signs as soon as they arrive. | |

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| Z501 SS = F | Continued from page 20<br>Standards for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2023 Edition<br><br>5.2.2 Pipe and Fittings, Sprinkler pipe and fittings shall be inspected annually from the floor level.<br><br>5.2.2.1 Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion.<br><br>5.3.1 Sprinklers<br><br>5.3.1.1 Where required by this section, sample sprinklers shall be submitted to a recognized testing laboratory acceptable to the authority having jurisdiction for field service testing.<br><br>5.3.1.1.1.3 Sprinklers manufactured using fact-response elements that have been in service for 20 years shall be replaced, or a representative sample shall be tested, they shall be re-tested at 10-year intervals.<br><br>5.3.1.1.5 Dry sprinklers that have been in service for 10 years shall be replaced, or representative samples shall be tested, they shall be re-tested at 10-year intervals.<br><br>5.3.1.1.6 Where sprinklers are subjected to harsh environments, including corrosive atmospheres and corrosive water supplies, on a 5-year basis, sprinklers shall either be replaced, or representative's sprinkler samples shall be tested.<br><br>5.3.1.2 A representative sample of sprinklers for testing per 5.3.1.1.1 shall consist of a minimum of not less than four sprinklers or 1 percent of the number of sprinklers per individual sprinkler sample, whichever is greater.<br><br>5.3.1.3 Where one sprinkler within a representative sample fails to meet the test requirement, all sprinklers within the area represented by that sample shall be replaced.<br><br>15.6 Emergency Impairments<br><br>15.6.1 Emergency impairments shall include, but are not limited to, system leakage, interruption of water supply, frozen or ruptured piping, and equipment failure.<br><br>15.6.2 When emergency impairments occur, emergency action shall be taken to minimize potential injury and damage. | Z501 | Maintenance Director will be responsible to ensure that fire panel error codes are cleared or assessed by the vendor as needed, and to ensure that all vendor reports with recommendations for repairs are followed up timely.<br><br>Maintenance Director will be responsible to ensure that smoke detectors and QR sprinkler heads are tested and replaced as required.<br><br>Maintenance Director will be responsible to provide Fire Watch training to staff as necessary.<br><br>Maintenance Director will audit weekly x 4 and then monthly x 3 or until substantial compliance has been achieved to ensure the doors are not propped open and the appropriate signage is displayed. Findings will be submitted to QAPI Committee.<br><br>Responsible Person: Maintenance Director<br><br>Date of Completion: 11/28/2025 | |

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| Z501 SS = F | Continued from page 21<br>15.6.3 The coordinator shall implement the steps outlined in section 15.5<br><br>15.5. Preplanned Impairment Programs<br><br>15.5.1 All preplanned impairments shall be authorized by the impairment coordinator.<br><br>15.5.2 Before authorization is given, the impairment coordinator shall be responsible for verifying that the following procedures have been implemented:<br><br>(4) Where a required fire protection system is out of service for more than 10 hours in a 24-hour period, the impairment coordinator shall arrange for one of the following:<br><br>(a) Evacuation of the building or portion of the building affected by the system out of service or;<br><br>(b) An approved fire watch<br><br>Appendix.15.5.2 (4)(b) A fire watch should consist of trained personnel who continuously patrol the affected area.<br><br>National Fire Protection Association (NFPA) 72 National Fire Alarm and Signaling Code, 202022 Edition<br><br>14.2.1.1 Performance Verification. To ensure operational integrity, the system shall have an inspection, testing and maintenance program.<br><br>14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacture's published instructions.<br><br>14.2.1.2.2 System defects and malfunctions shall be corrected.<br><br>14.4.5.3.1 Sensitivity shall be checked within 1 year after installation.<br><br>14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter, unless otherwise permitted compliance with 14.4.5.3.3.<br><br>14.4.5.3.5 Unless otherwise permitted by 14.4.5.3.6, smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. | Z501 | | |

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| Z501 SS = F | Continued from page 22<br>National Fire Protection Association (NFPA) 99 Healthcare Facilities Code (2024) Edition.<br><br>11.3 Cylinder and Container Storage Requirements.<br><br>11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of non-combustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.<br><br>11.3.2 Storage for nonflammable gases greater than (300 ft3) but less than (3000 ft3) shall comply with the requirements in 11.3.21 through 11.3.2.3.<br><br>11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.<br><br>11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:<br><br>1) Minimum distance of (20ft)<br><br>2) Minimum distance of (5ft) if the entire storage location is protected by an automatic sprinkler system.<br><br>3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour.<br><br>11.3.4 Signs<br><br>11.3.4.1 A precautionary sign, readable from a distance of (5ft), shall be displayed on each door or gate of the storage room or enclosure.<br><br>11.3.4.2 The sign shall include the following wording as a minimum:<br><br>"CAUTION: OXIDIZING GASE(ES) STORED WITHIN NO SMOKING"<br><br>Based on observation, interview, and document review, the facility failed to maintain compliance with state licensing and the 2024 edition of the NFPA 101 Life Safety Code by not ensuring staff received and documented proper fire watch training; maintaining the water-based fire protection systems; replacing or testing sprinkler heads beyond their service life; maintaining fire alarm system components including outdated smoke detectors; and properly storing and identifying medical oxygen cylinders. | Z501 | | |

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| Z501 SS = F | Continued from page 23<br><br>Findings include:<br><br>CITATIONS:<br><br>A. K345 Fire Alarm and Smoke Detection Testing and Maintenance<br><br>The facility failed to properly maintain the fire alarm control panel and supervised smoke detectors in accordance with NFPA 72 Standard for Fire Alarm and Signaling.<br><br>1) On 10/15/2025, during a tour of the facility, observation revealed the main fire alarm panel in the Maintenance Director's office displayed four trouble alarms and a vendor inspection tag marked "Deficient". Three of the trouble alarms were specific to a depressurization of the dry sprinkler system which was impaired and undergoing repair. The fourth trouble alarm was labeled "TBL D/D 200 WING AHU N-1" and was unrelated to the in-progress repair of the dry sprinkler system.<br><br>The vendor tag marked "deficient" attached to the main fire alarm panel, indicated nine photoelectric smoke detectors failed sensitivity and a duct detector in the air handling unit was inoperable.<br><br>During an interview, the Maintenance Director indicated that facility staff mistakenly believed the four trouble alarms on the main fire alarm panel were all related to the dry sprinkler system repair.<br><br>2) On 10/15/2025, during a review of the facility's Life Safety Code documentation, the facility provided a vendor inspection report titled, "FIRE ALARM AND LIFE SAFETY SYSTEM TESTING" dated 05/30/2025. The vendor inspection report indicated a failed "roof core east corridor AHU C-1" duct detector.<br><br>The facility failed to provide written records for the repair or replacement of the identified duct detector. Trouble alarm #4 on the main fire panel supported the finding identified by the vendor within the inspection report.<br><br>During an interview, the Maintenance Director indicated being hired 07/2025 and was unable to provide information on the vendor inspection findings from 05/30/2025.<br><br>3) On 10/15/2025, during a review of the facility's | Z501 | | |

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| Z501 SS = F | Continued from page 24<br>Life Safety Code documentation, the facility provided a vendor inspection report titled, "PM-FIRE ALARM SMOKE DETECTOR SENSITIVTY TEST-2 YEARS" dated 05/30/2025. The vendor inspection report indicated "(9) smoke detectors failed sensitivity test".<br><br>The facility failed to provide written records for the repair or replacement of the identified smoke detectors.<br><br>During an interview, the Maintenance Director indicated being hired 07/2025 and believed the (9) of (80) identified detectors were replaced with unsupervised battery-operated residential style smoke detectors within the facility corridors.<br><br>4) On 10/15/2025, during a review of the facility's Life Safety Code documentation, the facility provided a vendor report titled, "INVENTORY & WARRANTY REPORT", dated 05/30/2025. The Inventory & Warranty report identified 80 photoelectric smoke detectors by specific make and model number. The report indicated the photoelectric smoke detectors were manufactured prior to 1998 and were installed throughout the facility on 05/20/1998, which revealed a manufacture/install date greater than 27 years.<br><br>On 10/16/2025, a review was conducted for End of Life (EOL) and End of Service (EOS) manufacture bulletins for the identified photoelectric smoke detectors. The specific make and model of photoelectric smoke detectors was discontinued by the manufacturer on 05/29/2020. Although current sensitivity and functional testing records show 90 % of the devices installed in the facility are within tolerance, the specific make/model has been discontinued by the manufacturer with no new production and limited/no parts support.<br><br>The facility failed to maintain the operational integrity of its originally installed photoelectric smoke detectors, which are no longer supported or manufactured. These devices have been discontinued since 2020 and do not meet current maintenance or manufacturer service standards.<br><br>B. K353 Sprinkler System-Testing and Maintenance<br><br>The facility failed to properly maintain the wet and dry fire sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. | Z501 | | |

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| Z501 SS = F | Continued from page 25<br>1) On 10/15/2025, during a tour of the facility, observation confirmed the building's dry-sprinkler system to be impaired and depressurized. Further, observation revealed resident room #607 and #608 had experienced sprinkler system water leaks that originated above the ceiling. The leaks penetrated the monolithic ceiling into the resident rooms. Two residents had to be relocated for their protection and servicing of the system.<br><br>Observation of the dry system riser room revealed a vendor inspection tag dated 03/21/2025 marked as deficient. The reverse side of the vendor tag stated, "NITROGEN SYSTEM IN TROUBLE, SERVICE NEEDED". The facility failed to provide documentation showing immediate repair of the nitrogen system. The next vendor tag in series displayed a repair date of 06/16/2025. The reverse side of the vendor tag stated, "RESTORED DRY SYSTEM".<br><br>During an interview, the Maintenance Director indicated the facility's dry system was aged and had experienced a series of pressure leaks triggering supervisory alarms and the subsequent flooding of the dry pipe system. Once flooded, water leaks presented in multiple patient care areas and resident rooms. The Maintenance Director further indicated that each new leak necessitated a vendor repair response and that the dry system had been disabled pending an entire system inspection and that the facility had implemented a fire watch protocol.<br><br>During an interview, the vendor charged with repair indicated that the dry system sprinkler piping had experienced electrolysis in several areas above the ceiling and that the system appeared to be original to the facility which would place the system in service for more than 27 years. The vendor further indicated that each time a repair was made the system was repressurized, which in turn presented additional leaks.<br><br>The facility failed to maintain the building's water-based fire sprinkler protection system in accordance with NFPA 25 requirements and did not demonstrate proactive measures to anticipate age-related deterioration or system obsolescence in accordance with NFPA 101.<br><br>2) On 10/15/2025, during a review of the facility's Life Safety code documentation, a vendor inspection report titled," ODPM-FIRE SPRINKLER 5 YEAR INTERNAL | Z501 | | |

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| Z501 SS = F | Continued from page 26<br>INSPECTION" dated 02/26/2025 was provided. The vendor inspection report indicated that all wet-type quick response (QR) sprinklers heads 20 or more years old were replaced or successfully sample tested. The vendor inspection report further indicated that all dry-type sprinkler heads 10 years old or older were replaced or successfully sample tested.<br><br>The facility failed to provide written records for the replacement or sample testing results of the more than 20-year-old wet-type QR and more than 10-year-old dry-type sprinkler heads that were indicated within this inspection report.<br><br>3) On 10/15/2025, during a review of the facility's Life Safety code documentation, a vendor inspection report titled, "PM-FIRE SPRINKLER ANNUAL INSPECTION 100% HEADS-ANNUAL" dated 05/15/2025 was provided. The vendor inspection report indicated that all wet-type QR sprinklers heads 20 or more years old were replaced or successfully sample tested. The vendor inspection report further indicated that all dry-type sprinkler heads 10 years old or older were replaced or successfully sample tested.<br><br>In addition, the facility provided As-Built sprinkler system plans dated 07/26/1998, in which, three of five pages were inspected. Plan pages four and five were missing. The limited As-Built plans indicated the facility contained an excess of 359 wet-type QR and dry-type sprinkler heads installed in 1998. The actual sprinkler head count remained undetermined due to the two missing plan pages.<br><br>During an interview, the Maintenance Director indicated the facility had not replaced or sample tested the building's 20-year-old(er) wet-type QR or 10-year-old(er) dry-type sprinkler heads.<br><br>4) On 10/15/2025, during a tour of the facility, unoccupied resident room #608 was surveyed for Life Safety Code compliance. Observation revealed the resident room contained two side mounted wet-type QR sprinkler heads. The sprinkler head deflector plate contained the year, type, make, model, identification number, and applicable manufacture data. The sprinkler head deflector plate indicated the sprinkler head was manufactured in 1998 and was in fact type QR.<br><br>The facility failed to replace the QR wet-type sprinkler heads within 20 years of service or provide evidence of approved sample testing of a minimum four or 1% of the total sprinkler heads installed. | Z501 | | |

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| Z501 SS = F | Continued from page 27<br><br>5) On 10/15/2025, during a tour of the facility, an interview was conducted with the Supervisor of the building's sprinkler system repair company. The Supervisor indicated that the company was not the contracted vendor for the facility and was simply on site to repair leaks for the aged and dry-type sprinkler system. The Supervisor indicated the dry-type sprinkler system and sprinkler heads were located within the attic and interstitial spacing and appeared to contain all original materials.<br><br>The facility failed to replace the dry-type sprinkler heads within 10 years of service or provide written records of approved sample testing of a minimum four or 1% of the total sprinkler heads installed.<br><br>C. K354 Fire Watch Policy<br><br>The facility failed to provide evidence that 21 identified staff members received in-service training on fire watch functions, general fire safety, or specific concerns related to a current sprinkler impairment that necessitated a fire watch. The facility was unable to provide training records, curriculum, lesson plans, performance objectives, or documented evidence of the facility's fire watch functions in direct contrast to its established policy.<br><br>1) On 10/15/2025, during a review of the facility's Life Safety Code documentation, the facility provided policy #EDP-016 "FIRE SAFETY AND PROCEDURES" with an effective date of 04/25/2018. Line item #6 of the document stated, "any individual assigned to fire watch shall not perform any other assigned job duties". Line item #7 stated, "all personnel will be trained in our fire watch procedures". Only the Safety Officer, Administrator, or designee will assign fire watch duty and the assigned will undergo training in our fire watch functions prior to being assigned fire watch duties.<br><br>The policy failed to identify specific fire watch functions or physical actions utilized in fire watch implementation.<br><br>2) On 10/15/2025, during an interview, the Maintenance Director (MD) indicated also being the designated Safety Officer (SO) for the facility in addition to his full-time duties. The MD/SO indicated the facility had been on an extended fire watch due to an ongoing sprinkler system impairment. The MD/SO indicated the facility's maintenance staff were solely responsible for conducting fire watch and had documented their | Z501 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10962 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/22/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TLC CARE CENTER | 1500 W WARM SPRINGS RD , HENDERSON, Nevada, 89014 |

| (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 |
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| Z501 SS = F | Continued from page 28<br>actions on a facility form. The MD/SO provided a quantity of completed forms titled, "FIRE WATCH DOCUMENATION".<br><br>During a review of the provided fire watch logs, it was determined that there was incomplete coverage for several days, particularly the night shift hours of 10pm-6am. The MD/SO indicated the four-person maintenance team was unable to provide 24-hour fire watch coverage and as such, designated both clinical and non-clinical staff to assist. The MD/SO then produced an additional quantity of facility fire watch logs for the missing watch periods. Upon review, there was a total of 21 facility staff members identified who completed a fire watch log.<br><br>During an interview, the MD/SO indicated the facility could not provide evidence that the 21 staff members received training in fire watch functions. In addition, the MD/SO indicated the facility could not provide curriculum or documents that specifically illustrate fire watch functions in direct contrast to facility policy #EDP-016.<br><br>D. K923 Gas Equipment Cylinder and Container Storage<br><br>The facility failed to ensure medical gas storage rooms that contained oxygen cylinders were protected against unauthorized entry / potential tampering and contained the required caution signage.<br><br>1) On 10/15/2025 during a tour of the facility, observation revealed the entry door to the designated medical gas storage room adjacent to the 200 hall was propped open with an oxygen cylinder cart. Further observation revealed, the entry door to the designated medical gas storage room adjacent to the 600 hall was found unlocked when challenged.<br><br>The facility failed to ensure the oxygen storage rooms were protected from unauthorized entry and potential cylinder tampering.<br><br>2) On 10/15/2025, during a tour of the facility, observation revealed the two designated interior medical gas storage rooms were designated "Clean Utility" and "Nourishment Rooms". Further observation revealed signage to the right of the doors that read, "Oxygen Storage Flammable".<br><br>The facility failed to ensure the entry doors for the two designated interior oxygen storage rooms were | Z501 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10962 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/22/2025 |
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| (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 |
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| Z501 SS = F | Continued from page 29 equipped with signage that indicated oxidizing gas(es) were stored within. At a minimum, signage on the entry doors must read, CAUTION: OXIDIZING GASE(ES) STORED WITHIN NO SMOKING. | Z501 | | |