

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2025	
NAME OF PROVIDER OR SUPPLIER TRUE LOVING CARE II LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8020 FAIRFIELD AVE, LAS VEGAS, NEVADA ,89123		
(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
0000	<p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 03/10/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was eight. The sample size was five. The facility received a grade of A. There was one complaint investigated. Unsubstantiated: 1. Complaint #NV00073272 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the Complaint included: Observation of secured exit doors and operating alarms, grooming and physical appearance for residents, medication administration and a tour of the facility. Interviews were conducted with the resident of concern, residents, Caregivers, and the Owner. Clinical Record Review of five records, which included the resident of concern. Document Review included facility policy and procedures. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. There were no regulatory deficiencies identified. No further action is necessary. Please retain a copy for your records.</p>	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: REPRESENTATIVE'S SIGNATURE

Title:

Date:

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.