

Division of Public and Behavioral Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>10202</b>                                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/08/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TENDER LOVING MEMORY CARE &amp; ASSISTED LIVING HOME L</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>3429 WEST LONE MOUNTAIN ROAD, NORTH LAS VEGAS, NEVADA ,89031</b> |                                                                                                                          |                                                        |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br><b>0000</b>                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG<br><br><b>0000</b>                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                             |
|                                                                                                   | <p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey at your facility on 03/08/22. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons, with endorsements for Alzheimer Disease and Assisted Living services, Category II residents. The census at the time of the survey was six. Six resident files and six employee files were reviewed. The facility received a grade of A. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:</p> |                                                                                                                  |                                                                                                                          |                                                        |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: LEO WONG Title: Owner Date: 03/16/2022  
REPRESENTATIVE'S SIGNATURE

Division of Public and Behavioral Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>10202</b>                                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/08/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TENDER LOVING MEMORY CARE &amp; ASSISTED LIVING HOME L</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>3429 WEST LONE MOUNTAIN ROAD, NORTH LAS VEGAS, NEVADA ,89031</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                        |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br><b>0072<br/>SS= D</b>                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG<br><br><b>0072</b>                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X5)<br>COMPLETION<br>DATE<br><br><b>03/16/2022</b>    |
|                                                                                                   | <p>Qualifications of Caregiver - Med Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.0302, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and (d) Annually pass an examination relating to the management of medication approved by the Bureau.</p> <p>Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 6 employees received 8 hours of annual training in medication management. (Employee #5). Findings include: Employee #5 was hired as a caregiver on 10/04/21. The employee file contained documentation that the medication management training certificate expired on 02/20/22 . On 03/08/2022 in the afternoon, Employee #1 acknowledged the missing training certificate. Severity: 2<br/>Scope: 1</p> |                                                                                                                  | <p>POC</p> <ol style="list-style-type: none"> <li>1. Administrator and owner immediately contacted a third party provider to conduct medication training to the said employee.</li> <li>2. Administrator and owner will make sure all trainings needed by employees are completed in a timely manner by sending out reminders at least a month prior expiration of training.</li> <li>3. Administrator reiterated to staff the importance of keeping track of their training renewal dates. It is their responsibility to know when their renewal dates are.</li> <li>4. Administrator and owner will make sure that plan of correction is executed.</li> <li>5. Employee completed required training on March 16, 2022. Please see copy of medication training certificate.</li> </ol> |                                                        |