Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10202	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER LOVING MEMORY CARE & ASSISTED LIVING HOME L	3429 WEST LONE MOUNTAIN ROAD, NORTH LAS VEGAS, NEVADA ,89031

(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	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 03/27/25 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's Disease, Assisted Living Services, Category II residents. The census at the time of the survey was ten. Ten resident files and eight employee files were reviewed. The facility received a grade of A. 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 regulatory deficiencies were identified:	0000		

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 REPRESENTATIVE'S SIGNATURE Name: LEO WONG Title: Owner Date: 04/04/2025

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0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to maintain a clean exterior environment. Findings include: On 03/27/25 in the morning, the following were observed in the yard during a tour of the facility: -Multiple wood pallets on the west side of the house were propped up against the wall. -A large gray bucket full of water was in front of the garage door. -A large gray bucket full of dirt and another one with wiring was located along the west side of the house. -Miscellaneous tubing, wood pieces, a broken metal love seat, multiple black plastic bags were throughout the yard with unidentified contents and chairs were stacked along the west side of the house. -A white passenger transport van was in the back of the house, the wheels were covered with cardboard and had expired license plates from February 2021. On 03/27/25 in the morning, the Administrator and a Caregiver confirmed the observations. The Administrator explained the van belonged to the Owner of the house. Severity: 2 Scope: 3	0178	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); All exterior items mentioned have been removed and the space has been tidied up. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); No items will be placed in the exterior of the house from here on out. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Owner will do bi-weekly walk arounds to ensure the space is tidy and organized. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Owner will do bi-weekly walk arounds to ensure the space is tidy and organized. 5) The date the corrective action will be completed (MUST INCLUDE); AND Correction was already made on 3/27/25 6) You must attach all supporting documents into the system (MUST INCLUDE). Attached.	04/02/2025

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0995 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor activities; (2) Has at least 40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times. Inspector Comments: Based on observation and interview, the facility failed to ensure a gate leading to an open yard in the back of the house was locked. Findings include: On 03/27/25 at 9:45 AM, the gate on the north side of the house leading to the backyard, was unlocked. The gate led to an open, unsecured backyard area, leading to the street in front of the facility. On 03/27/25 at 9:45 AM, the Caregiver confirmed the gate was unlocked and explained the gate was unlocked during the day and locked at night. Severity: 2 Scope: 3	0995	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); The lock on the gate is now locked 24 hours a day and will only be unlocked in case of an emergency. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); The lock has already been locked and will remain as such. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Staff will do daily checks to ensure the lock stays locked. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Owner has already completed. 5) The date the corrective action will be completed (MUST INCLUDE); AND This was already corrected on 3/27/25, the day of the survey. 6) You must attach all supporting documents into the system (MUST INCLUDE). Attached.	04/02/2025