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
	11668	A. BUILDING _____ B. WING _____	08/27/2025

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TLC COSTA BRAVA	6737 COSTA BRAVA RD, LAS VEGAS, NEVADA ,89146-6573

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RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey initiated at your facility on 08/27/2025. The facility is licensed for ten Residential Facility for Group beds for persons with mental illness and/or Alzheimer's disease, Category II residents. The census at the time of the survey was ten. Ten resident files and six employee's files were reviewed. The facility received a grade of C.			
Y 0106 SS= F	NAC 449.0113 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is	Y 0106	These findings were corrected on 8/27/25, and the person responsible for the correction and who implemented them was the Administrator. It was corrected by Employees #E1, E5, and E6 having gone to the in-person CPR course held the evening of 8/27/25. All CPR cards are attached here and were e-mailed to Surveyor within	08/27/2025

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	currently certified to perform first aid and cardiopulmonary resuscitation. Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 6 employees received an in-person cardiopulmonary resuscitation (CPR) training. (Employee #1, #4, #5, #6) Findings include: Employee #1 (E1) E1 was hired on 07/11/19 as the House Manager. E1's file revealed CPR training was completed online on 08/23/25. E1's record lacked documented evidence of the CPR in person component. Employee #4 (E4) E4 was hired on 05/15/24 as a Caregiver. E4's record lacked documented evidence of CPR training with an in-person component. Employee #5 (E5) E5 was hired on 09/01/23 as a		24 hours of the survey. #E5 was listed here accidentally, I think, this employee took his in-person CPR on 6/21/2024. Evidence of this CPR is attached to this SOD and this wasn't discussed on 8/27/25, but CPR evidence is on site at facility. The systematic measures that are put in place to ensure that this practice does not recur is that Administrator has started a list of online schools to alert herself if these certificates are turned in by staff and added these schools to the staff messaging system as unacceptable schools. Administrator already has a spreadsheet tickler system that reminds Administrator of the due dates for each staff members training dates. Administrator added a calendar reminder for each month to double check the tickler system to keep up with required items that are time sensitive.	

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	Caregiver. E5's file revealed CPR training was completed online on 08/14/25. E5's record lacked documented evidence of the CPR in person component. Employee #6 (E6) E6 was hired on 10/10/21 as a Caregiver. E6's file revealed CPR training was completed online on 08/14/25. E6's record lacked documented evidence of the CPR in person component. On 08/27/25 in the afternoon, the Administrator acknowledged E1, E4, E5 and E6 lacked documented evidence of completing CPR training with an in-person component. Severity: 2 Scope: 3			
Y 0172 SS= F	**NAC 449.209** 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in	Y 0172	These findings were corrected on 8/27/25, and the person responsible for the correction and who implemented this was the Owner. It was corrected by the hired yard waste removal company. All yard clippings were hauled away on 8/27/25. Prior to this date, the yard clippings were neatly tucked away behind a shed and a rock feature in the backyard to keep paths clean and secure. The systematic measures that are put in place to ensure that this practice does not recur is that Administrator has added a calendar reminder for each month to double check the backyard, even behind the shed and	08/27/2025

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	the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. 4. To the extentpracticable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 5. Theadministrator of a residential facility shall ensure that the premises areclean and that the interior, exterior and landscaping of the facility are wellmaintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the premises were clean and well maintained.		other nooks and crannies to ensure that Owner continues to keep up the landscaping of the facility.	

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	Findings include: The following observations were made on 08/27/25 in the morning: -Old Yard Clippings (debris pile) behind large water feature on perimeter wall -Old wood branches (debris pile) along the side of water feature -Old discarded wood & fabric dining chairs with cigarette ashtray on last chair seat On 08/27/25 in the morning, the Administrator designee acknowledged the facility failed to ensure the premises were cleaned and well maintained. Severity: 2 Scope: 3			
Y 0430 SS= F	NAC 449.229 **Safety requirements for residents with restricted mobility or poor eyesight; water hazards; auditory systems for bathrooms and bedrooms; access by vehicles.** 1. A resident of a residential facility who uses a wheelchair or a walker must not be required to use a bedroom on a floor other than the first floor of the facility that is entirely above the level of the ground,	Y 0430	These findings were corrected on 10/7/25, and the person responsible for the correction and who implemented this correction was the Administrator. It was corrected by On Guard Fire, who came to the facility on 8/27/25 and determined that the fire panel issues and the smoke detectors that cause the issues were not causing harm to the residents and occupants of the facility. The smoke alarms and the panel were fixed on10/7/25 as it took a little while for On Guard to have the necessary replacement materials shipped to them. The systematic measures that are put in place to ensure that this practice	10/07/2025

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	unless the facility is designed and equipped in such a manner that the resident can move between floors without a assistance. 2. Stairways, inclines, ramps, open porches and other areas that are potentially hazardous for residents who have poor eyesight must be adequately lighted. 3. If a residential facility with a resident who mentally or physically disabled has a fishpond, pool, hot tub, Jacuzzi or other body of water on the premises of the facility, the body of water must be fenced, covered or blocked in some other manner at all times when it is not being used by a resident. Inspector Comments: Based on observation and interview, the facility failed to ensure the fire system was well maintained. Findings include: On 08/27/25 in the morning, the facility fire system displayed a warning on the screen which read, "System Trouble".		does not recur is that Administrator has added a calendar reminder for each month to double check the vents, to ensure that they don't get too dusty, and hence not to cause any issues with the panel, and has re-trained staff on the monthly fire drill requirement, during which they are to double check that all smoke alarms are functioning.	

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	On 08/27/25 in the afternoon, a Fire Alarm technician reported the smoke alarms were dirty, and the technician cleared the smoke detectors while onsite. According to the technician, the panel also needed to be replaced as two smoke alarms were assigned the same number on the panel. On 08/27/25 in the afternoon, the Administrator acknowledged the fire system panel read trouble and verbalized the facility had recently dusted which may have tripped the panel. Severity: 2 Scope: 3			
Y 0878 SS= E	NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician , physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician , physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this	Y 0878	These findings were corrected on 8/27/25, and the person responsible for the correction and who implemented these was the Administrator. It was corrected by requesting the items from the pharmacy and from the providers. Proof of these corrections were emailed on8/27/25 and some on 8/28/25 and the corrections were as follows: R2 – Aspercreme Pad was delivered and proof of that was sent, and is now attached. It was not administered because it is As Needed and resident did not need it. The entire time of this order, resident had needed it twice only, in the past. R3 – the Lidocane patch and Polyvinyldrops were delivered on 8/27/25, proof was emailed, and is now attached.	08/27/2025

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	subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse.. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, document review, record review and interview, the facility failed to ensure medications were onsite to administer to 3 of the 10 sampled residents (Resident #2, #3, and #5).		R1 – (not R4) – did have suppository on site, proof of that was emailed, however, DC order was obtained, and was also sent, and now attached. The systematic measures that are put in place to ensure that this practice does not recur is that Administrator added a calendar reminder for each month to double check the med audits completed by Med Techs and to do a med audit spot check monthly. Additionally, Owner hired an outside Med Tech Consultant to do med audits monthly to prevent any mistakes like these from happening in the future.	

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	Findings include: Resident #2 (R2) R2 was admitted on7/10/24 with a primary diagnosis of Dementia, High Blood Pressure (HTN), Diabetes Type II and Fracture of Hip. On 8/27/25 in the morning, A physician order dated 07/10/24 documented Aspercreme Pad with Lidocaine 4%, Apply 1 patch to neck/shoulder once daily as needed for pain. Remove after 24 hours. The medication was not on site. The August 2025 Medication Administration Record (MAR) lacked documented evidence the medication had been administered as prescribed any day of the month. The medical technician (MT) verbalized the facility did not notify the prescriber of the need for refill but would do so immediately. Resident # 3 (R3) R3 was admitted on08/30/25 with a primary diagnosis of Dementia, Arthritis, hypothyroidism, osteoporosis, macular degeneration, skin irritations, and dry eye syndrome.			

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	On 08/27/25 in the morning, a physician order dated 08/18/25 for Lidocaine Pain relief patch (4%-transdermal), Apply one patch transdermal every day to right knee. Apply at 8 AM and remove at 8 P, for knee pain. The medication was not on site. On 08/27/25 in the morning, a Physician order for Polyvinyl Alcohol Ophthalmic Solution (1.4%-Ophthalmic) Place one drop in each eye once daily. The medication was not on site to administer to the resident. The August 2025 (MAR)-documented the Lidocaine medication was requested for refill with notation documenting Issues with supply-pharmacy notified. The MAR documented notes entered by MT ‘s to refill the Polyvinyl Alcohol Ophthalmic Solution on 08/24/25-08/26/25 with notation documenting “Issues with supply-pharmacy notified on 08/27/25.” The MT confirmed the medications were not onsite but had been requested and would be delivered to the facility by 6 PM. Resident #4 (R4) R4 was admitted on April 11, 2025 with a primary diagnosis of			

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	Dementia, HTN, Thyroid Deficiency. On 08/27/25, in the morning, a physician order dated 06/03/25 for Bisacodyl. (10 MG-Rectal) Unwrap and insert 1 suppository per rectum everyday as needed if no bowel movement for 3 days, for Constipation. The medication was not on site to administer to the resident. The August 2025 MAR ~~l~~acked documented evidence the medication had been administered as prescribed any day of the month. On 08/27/25 at 2:47PM, The medical technician (MT) verbalized the facility did not notify the prescriber of the need for refill but would do so immediately. The MT advised the medication would be scheduled for next day delivery. On 08/27/25 in the morning, the Administrator designee acknowledged the medications were not site for 3 of 10 residents. Severity: 2 Scope: 2			

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Y 0994 SS= F	**NAC 449.2756** **Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personnel required;** (e) Knives, matches, firearms, tools, and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic items were secure. Findings include: On 08/27/25, in the morning, bleach cleaner and a disposable razor were unsecured in the hallway bathroom between bedrooms 9, and 5. On 08/27/25 in the morning, the Administrator designee acknowledged the unsecured bleach cleaner, and disposable razor should have been locked up. Severity: 2 Scope: 3	Y 0994	These findings were corrected on 8/27/25, and the person responsible for the correction and who implemented these was the Administrator. It was corrected by locking up the bleach and the razor that was left out in the bathroom. The systematic measures that are put in place to ensure that this practice does not recur is that Administrator added a calendar reminder for each month to double check the dangerous items during walkthroughs. Administrator also added a task to House Manager to walk through and look for these items, so staff can beheld accountable on-going. Additionally, Owner hired an outside Med Tech Consultant to do walk throughs for the same purpose.	08/27/2025
Y 1840 SS= D	**R063-21 Sec. 4.** Sec. 4. 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization	Y 1840	This finding was corrected on 8/27/25, and the person responsible for the correction and who implemented it was the Administrator. It was corrected by the effected and listed Employee, who logged in the day of survey and completed the online provided Infection Control training that day. Certificate is attached here and	08/27/2025

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	concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 6 sampled employees completed the annual required infection control training for unlicensed caregivers (Employee #4). Findings include: Employee #4 (E4) E4 was hired on 05/15/24 as a Caregiver. E4 completed annual infection control training on 03/25/24. E4's file lacked documented evidence of 2025 annual infection control training through a nationally recognized organization.		were e-mailed to Surveyor and given in paper format the day of survey. The systematic measures that are put in place to ensure that this practice does not recur is that Administrator added a calendar reminder for each month to double check the tickler system to keep up with required items that are time sensitive, and re-remind staff if they are late with their responses. Administrator already has a spreadsheet tickler system that reminds Administrator of the due dates for each staff members training dates. Administrator will check this system on a monthly basis so this does not	

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	On 04/30/25 in the afternoon, the Administrator acknowledged E4's missing infection control training and was unable to provide the documentation while onsite. Severity: 2 Scope: 1			