STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305	A. BUILDING _____ B. WING _____	09/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHERS BEST CARE FOR THE ELDERLY	1225 S 8TH STREET, LAS VEGAS, NEVADA ,89104

(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
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 a complaint survey completed in your facility on 09/01/26. The facility is licensed for ten Residential Facility for Group beds for persons with mental illness, Category II residents. The census at the time of the survey was nine. The sample size was six. The facility received a grade of A. There was one complaint investigated. Substantiated: 1. Complaint #14037 was substantiated. See Tags 671 and 1225. The investigation of the complaint included: Interviews were conducted with residents, a Caregiver, and the Administrator. Clinical Record Review of one record, which included the resident of concern. Document Review included facility policy and procedures and the facility's incident report database.			
Y 0671 SS= D	**NRS 449A.284 and NRS 449A.286 NRS 449A.284 Notices concerning discharge of resident** 1. Written notice of the intent of a residential facility for groups to discharge a resident provided pursuant to NRS 449A.114 must, in addition to	Y 0671	I was not going to admit R1 to begin with. In fact, I told the Marketer, Rommel Timbal to find her another place because it was not an immediate transfer and I didn't want to wait. I initially spoke to the husband on 4/16/26. The move-in date they told me was 5/8/26 (actual move-in 5/7/26). Rommel got back to me after a few days after the husband was presented with another option. Rommel told me that husband	09/25/2026

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	the persons described in that section, be provided to the representative of the patient, where applicable, and must include, without limitation: (a) The reason for the proposed discharge; and (b) The date of the proposed discharge. 2. Except as otherwise provided in this subsection, written notice of the intent of a residential facility for groups to discharge a resident pursuant to NRS449A.114 must be provided to a resident in a language that the resident or the representative of the resident, if applicable, is capable of reading. If the written notice is not provided in such a language, the facility must provide a translator who has been trained to assist the resident or the representative of the resident, if applicable, in the appeal process. 3. A residential facility for groups shall provide to a resident or a representative of the resident written notice of the location of the discharge of the resident not later than 10 days after providing written notice of the proposed intent to discharge the resident pursuant to NRS 449A.114. **NRS 449A.286 Assistance to and consultation with resident concerning discharge.** 1. Before discharging a resident, a residential facility for groups shall offer assistance to the resident and any representative of the resident concerning the discharge and relocation of the resident. Such assistance must include, without limitation, information on available alternative placements. 2. Except in an emergency, a		really wanted to go to us. The husband begged me to take R1 in. He asked what he needs to do to secure the spot. I told him he needs to pay a hold deposit (I explained is non-refundable). And when they move-in in May to pay for the month of May (details in the agreement that we both signed). I did not give them a written notice because they were informed immediately of the intent to discharge. It was stated in the agreement that termination of agreement can be written or verbal. I was also told that the husband did not want to talk to me. We coordinated thru the Marketer. It took the husband a few days to decide and take that option (12 days). I did not leave them in the cold. I know that the Marketer was assisting them in finding an appropriate placement which he already had in the first place, Ri was transferred to Garden Breeze Alzheimers Villa, 950 Garden Breeze Way, Las Vegas, NV 89123. This facility was actually the other option that was given them when they insisted on moving in with us. Because it was done promptly, I failed to properly document the events which was my shortcoming. Moving forward, to avoid this deficiency, we will make sure to document all events. Additionally, a Refund and Discharge Policy was put into place that is effective immediately to be part of our facility practices. Hopefully this will prevent this deficiency to reoccur. (Copy attached) Person Responsible: Administrator Date Corrected: Immediately	

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	residential facility for groups shall involve a resident and his or her representative, if applicable, in planning the relocation of the resident and allow the resident or his or her representative to choose among the available alternative placements. Any emergency placement must be temporary and must terminate when the resident or his or her representative is able to offer input on the final decision concerning the placement of the resident. A residential facility for groups shall not require a resident to remain in a temporary or permanent placement. 3. In nonemergency situations, and where possible in an emergency, a residential facility for groups that transfers or discharges a resident shall, in consultation with the resident and his or her representative, if applicable, design and implement a transition plan in advance of the transfer or discharge. 4. A residential facility for groups is not in violation of this section or subject to disciplinary action if: (a) A resident returns to the facility after an emergency transfer or discharge; and (b) The emergency transfer or discharge was necessary to address health care needs of the resident which are outside the scope of care that the facility is legally authorized to provide Inspector Comments: Based on record review and interview, the facility failed to ensure a written notice of the intent to discharge a resident was provided, for 1 of 9 residents. (Resident #1) Findings include:			

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	Resident #1 (R1) R1 was admitted on 05/08/26 with diagnoses including metabolic encephalopathy and unspecified dementia. R1's record included a Physicians Placement assessment dated 05/07/26 indicating that R1 was categorized as appropriate for placement in a Category II Residential Facility for the Elderly and disabled. The assessment determined that R1 met the criteria and was appropriate for the facility. R1's record revealed a discharge summary completed on 05/19/26 at 2:30PM recording that R1 was discharged to another group home. The discharge summary lacked documented evidence as to why R1 was being discharged or the exact location of where R1 was being discharged to. R1's record lacked documented evidence of a 30-day written discharge notice provided to R1 or their representative including the reason for the proposed discharge and the date of the proposed discharge. On 09/01/26 in the morning, the facility's incident reports database revealed a lack of documented evidence of events documenting how R1 was not appropriate for the facility. On 09/01/26 in the morning, the Administrator relayed the staff were unable to physically handle R1 due to needing a two person assist for all tasks, needing a higher level of care than the facility could provide and had a dementia diagnosis the facility could not appropriately care for. The Administrator relayed they told R1's			

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	Power of Attorney on 05/08/26 that they should find R1 another facility due to the facility not being able to care for R1 due to R1 being above the level of care the facility was able to provide. The Administrator reported not knowing where R1 was discharged to. On 09/01/26 in the morning, the Administrator acknowledged there was no documentation of R1's behavior leading to R1's discharge and no written discharge notices were provided to R1 or their representative. Severity:2 Scope:1 Complaint #14037			
Y 1225 SS= D	**NRS 449A.114** Certain facilities to notify patient and State Long-Term Care Ombudsman of intent to transfer patient and provide opportunity for patient or representative to meet with administrator, exceptions. 1. Except as otherwise provided in subsection 2, before a facility for intermediate care, facility for skilled nursing or residential facility for groups transfers a patient to another medical facility or facility for the dependent or discharges the patient from the facility, the facility shall: (a) At least 30 calendar days before transferring or discharging the patient, provide the patient	Y 1225	As stated on my response to Tag Y 0671, it was a shortcoming on my part for not having documentation due to the spontaneity of the events. I didn't not think to give a written notice because my agreement indicates that termination of agreement can be written or verbal. And since the other party opted not to talk to me we continue to coordinate thru the Marketer. I was also assured that the Marketer had already found an appropriate placement which was available from day 1. It was the husband who took his time to make the decision to take it. I did confirm that this situation was not reported to the Ombudsman simply because I did not see a need to and I thought I acted promptly to help rectify the situation. However, later on I found out from my Staff that this was mentioned to our Ombudsman Michelle on her visit on 05/09/26. Again, I have no documentation of it. Moving forward, we will make sure that all events are going to be documented. Additionally, a Refund and Discharge Policy was put into place that is effective immediately as part of our facility practices. This hopefully will prevent this deficiency to reoccur. Person Responsible: Administrator Date Corrected: Immediately	09/25/2026

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	and the Ombudsman with written notice of the intent to transfer or discharge the patient; and (b) Within 10 calendar days after providing written notice to the patient and the Ombudsman pursuant to paragraph (a), allow the patient and any person authorized by the patient the opportunity to meet in person with the administrator of the facility to discuss the proposed transfer or discharge. 2. The provisions of this section do not apply to: (a) A voluntary discharge or transfer of a patient to another medical facility or facility for the dependent at the request of the patient; or (b) The transfer of a patient to another facility because the condition of the patient necessitates an immediate transfer to a facility for a higher level of care. 3. As used in this section, "Ombudsman" means the State Long-Term Care Ombudsman appointed pursuant to NRS 427A.125. Inspector Comments: Based on record review and interview, the facility failed to ensure a written 30			

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	calendar day notice of intent to discharge a resident was given to the Ombudsman's office for 1 of 9 residents. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 05/08/26 with diagnoses including metabolic encephalopathy and unspecified dementia. R1's record revealed a discharge summary completed on 05/19/26 at 2:30PM recording that R1 was discharged to another group home. R1's record revealed a lack of documented evidence the Ombudsman was notified of an intent to discharge R1 including the reason for the proposed discharge and the date of the proposed discharge. On 09/09/26 in the morning, the Administrator confirmed the Ombudsman was not notified of R1's intent to discharge from the facility and no written discharge notices were provided to R1, their POA or the Ombudsman. Severity: 2 Scope: 1 Complaint #14037			