STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5742	A. BUILDING _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH GROUP HOME, LLC.	6112 FISHER AVE, LAS VEGAS, NEVADA ,89130

(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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5742	A. BUILDING _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH GROUP HOME, LLC.	6112 FISHER AVE, LAS VEGAS, NEVADA ,89130

(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
	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 State Licensure survey completed at your facility on 03/18/26, 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 and/or persons with Alzheimer's disease and/or mental illness, 10 Category II residents. The census at the time of the survey was eight. Eight resident files and four employee files were reviewed. The facility received a grade of A.			
Y 0515 SS= D	NAC 449.259 **Supervision of residents.** 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services;	Y 0515	1. The care plan was completed and signed. 2. The administrator and manager will ensure the care plans are fully complete and signed. 3. The administrator will continue to audit files to ensure they are complete. 4. Administrator and Manager. 5. 3/18/26.	03/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5742	A. BUILDING _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH GROUP HOME, LLC.	6112 FISHER AVE, LAS VEGAS, NEVADA ,89130

(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
	(b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on interview and record review, the facility failed to complete a care plan, upon admission, for 1 of 8 residents (Resident #2). Findings include: Resident #2 (R2) was admitted on 06/26/25 with diagnoses including dementia and bowel disorder. Review of R2's medical record revealed a care plan dated 06/26/25, that was incomplete and unsigned.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5742	A. BUILDING _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH GROUP HOME, LLC.	6112 FISHER AVE, LAS VEGAS, NEVADA ,89130

(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
	On 03/18/26 in the morning, a manger confirmed the care plan for R2 was never completed or signed off. Severity: 2 Scope: 1			
Y 0720 SS= D	**NAC 449.2716** **Residents having colostomy or ileostomy.** 1. A person who has a colostomy or ileostomy must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The resident is mentally and physically capable of properly caring for his colostomy or ileostomy, with or without assistance, and the resident's physician has stated in writing that the colostomy or ileostomy is completely healed; or (b) The care for the colostomy or ileostomy is provided by a medical professional who is trained to provide that care. 2. The caregivers employed by a residential facility with a resident who has a colostomy or ileostomy shall ensure that: (a) All bags used by the resident are discarded appropriately; and (b) Privacy is afforded to the resident when care for the colostomy or ileostomy is being provided. Inspector Comments: Based on interview and record review, the facility failed to obtain an exemption to retain a resident with a colostomy bag, for 1 of 8 residents	Y 0720	1. A medical waiver for the colostomy has been submitted. 2. The manager and administrator will ensure appropriate waivers are submitted and approved with HCQC when required. 3. The administrator will check on residents more often and ensure any changes that require a waiver are submitted in a timely manner. 4. Administrator and Manager. 5. 3/24/2026 (applied for waiver).	03/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5742	A. BUILDING _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH GROUP HOME, LLC.	6112 FISHER AVE, LAS VEGAS, NEVADA ,89130

(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
	(Resident #2). Findings include: Resident #2 (R2) was admitted on 06/26/25 with diagnoses including dementia and bowel disorder. Hospice care plan dated 06/26/25 documented R2 required the use of a colostomy bag. Colostomy bag care was completed by hospice due to R2 being unable to do it on their own. Review of R2's record did not document an approved exemption to retain R2 in the facility. On 03/18/26 in the morning, a manager confirmed R2 had a colostomy bag, required assistance with the care of the colostomy bag and did not have an approved exemption to remain in the facility. Severity: 2 Scope: 1			
Y 0878 SS= D	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	1. The medication that was not in the facility was delivered the day of survey 3/18/26. 2. The manager and lead med-tech will follow-up on refills that were requested but not received. 3. The manager and lead med-tech will go through medications often and order refills at least one week a head of time. 4. Manager and Administrator. 5. 3/18/2026.	03/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5742	A. BUILDING _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH GROUP HOME, LLC.	**6112 FISHER AVE, LAS VEGAS, NEVADA ,89130**

(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
	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, interview and record review, the facility failed to ensure all medications were onsite and available for administration to 1 of 8 residents (Resident #3). Findings include: Resident #3 (R3) was admitted on 12/23/25 with diagnoses including type 2 diabetes mellitus ad dementia.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5742	A. BUILDING _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH GROUP HOME, LLC.	6112 FISHER AVE, LAS VEGAS, NEVADA ,89130

(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
	Physicians order dated 12/22/25 documented Amlodipine, 10 milligrams tablet, take one tablet daily at 8:00 AM. Review of Medication Administration Record (MAR) for March 2026 revealed R3 had not received Amlodipine on 03/17/26 or 03/18/26. On 03/18/26 in the morning, Amlodipine was not found on the medication cart for R3. On 03/18/26 in the morning, a Caregiver confirmed R3 ran out of Amlodipine on 03/16/26 and a refill had not yet been received. Severity: 2 Scope: 1			