

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/15/2026  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                       |                                                                                                                          |                                                                                                 |                            |                                                        |  |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                            |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/10/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOTHER'S BEST CARE FOR ELDERLY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                       |                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>1225 S 8TH STREET, LAS VEGAS, NEVADA ,89104</b> |                            |                                                        |  |
| (X4)<br>ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                                                 | (X5)<br>COMPLETION<br>DATE |                                                        |  |
| 0000                                                                      | Initial Comments<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of a mandatory regrading survey conducted at your facility on 01/09/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for ten Residential Facility for Group beds for persons with mental illness, Category II residents. The census at the time of survey was ten. Ten resident files and two 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                                                  |                                                                                                                          |                                                                                                 |                            |                                                        |  |
| 0100<br>SS= E                                                             | Personnel File - NAC 449.200 & R043-22 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his or her employment at the residential facility; (c) Records relating to the training received by the employee, including, without limitation: (1) Certificates of completion for all training completed by the employee; and (2) If a tier 2 training is not provided through a course listed on the Internet website maintained by the Division pursuant to subsection 2 of section 7 of this regulation, a list of topics covered by the training which may consist of, without limitation, the syllabus for the training or an outline of the training; (e) Evidence that the references supplied by the employee were checked by the residential facility. | 0100                                                  |                                                                                                                          |                                                                                                 | 01/21/2025                 |                                                        |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: KAREN M TATLONGHARI, RFA

Title: Administrator

Date: 01/21/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                       |                                                                                                                                                                                                                                |                                                                                                 |                            |                                                        |  |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                            |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/10/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOTHER'S BEST CARE FOR ELDERLY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                       |                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>1225 S 8TH STREET, LAS VEGAS, NEVADA ,89104</b> |                            |                                                        |  |
| (X4)<br>ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                       |                                                                                                 | (X5)<br>COMPLETION<br>DATE |                                                        |  |
| 0104<br>SS= E                                                             | Personnel Files - Background Checks -<br>NAC 449.200 Personnel files. (NRS<br>449.0302) 1. Except as otherwise provided<br>in subsection 2, a separate personnel file<br>must be kept for each member of the staff<br>of a facility and must include: (f) Evidence of<br>compliance with NRS 449.122 to 449.125,<br>inclusive.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0104                                                  |                                                                                                                                                                                                                                |                                                                                                 | 01/21/202<br>5             |                                                        |  |
| 0250<br>SS= D                                                             | Kitchens- Equipment Works; Clean And<br>Sanitary - NAC 449.217 Kitchens; storage<br>of food; adequate supplies of food; permits;<br>inspections. (NRS 449.0302) 1. The<br>equipment in a kitchen of a residential<br>facility and the size of the kitchen must be<br>adequate for the number of residents in the<br>facility. The kitchen and the equipment must<br>be clean and must allow for the sanitary<br>preparation of food. The equipment must be<br>in good working condition.<br><br>Inspector Comments: Based on observation<br>and interview, the facility failed to ensure<br>the refrigerator was in proper working order.<br>Findings include: On 01/09/25, in the<br>morning, the bottom drawer had a silver<br>band of tape holding it together. The drawer<br>from the second to the bottom had brown<br>tape holding it together. On 01/09/25, at<br>10:00 AM, the Administrator confirmed a<br>drawer and shelves in the refrigerator<br>needed to be repaired or replaced. Severity:<br>2 Scope: 1 | 0250                                                  | Administrator ordered new refrigerator<br>bins.<br><br>It will be delivered on 01/24/2025.<br><br>Administrator will pay closer attention to the<br>maintenance of kitchen appliances to<br>prevent this from happening again. |                                                                                                 | 01/21/202<br>5             |                                                        |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |  |                                                        |  |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                            |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/10/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOTHER'S BEST CARE FOR ELDERLY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>1225 S 8TH STREET, LAS VEGAS, NEVADA ,89104</b> |  |                                                        |  |
| (X4)<br>ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |  | (X5)<br>COMPLETION<br>DATE                             |  |
| 0276<br>SS= F                                                             | <p>Service of Food-Nutritious Meals;Frequency - NAC 449.2175 Service of food 7. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. At least three meals a day must be served at regular intervals. The times at which meals will be served must be posted. Not more than 14 hours may elapse between the meal in the evening and breakfast the next day. Snacks must be made available between meals for the residents who are not prohibited by their physicians from eating between meals.</p> <p>Inspector Comments: Based on observation and interview, the facility failed to ensure food was not expired, properly labeled and suitable for residents. Findings include: On 01/09/25 in the morning, the following was observed in the refrigerator: - A container of pickles with an expiration date of 10/09/23. - A bottle of sweet and sour sauce with an expiration date of 09/28/20. - A bottle of Italian dressing with an expiration date of 08/28/22. - Multiple yogurt containers with unidentified food inside, no package date, and no throw away dates. There were no updated hand written dates on the containers other then the manufacturer's expiration dates. On 01/09/25 in the morning, the Administrator confirmed there were expired items in the refrigerator and there were miscellaneous food stored in old yogurt containers which did not indicate what the item was, when it was stored, and when it needs to be removed or used by. Severity: 2 Scope: 3 Repeat deficiency from survey dated 10/01/24.</p> | 0276                                                  | <p>Administrator mandated the staff to stop using empty food containers such as yogurt or margarine tubs as leftover storage.</p> <p>Administrator bought actual food storage container and labels for the staff to label and date the leftover food.</p> <p>Staff was also told not to use the dressing/condiment bottles for refill to prevent showing an expired date on the bottle.</p> <p>Administrator will pay closer attention to these details such as expiration dates and labels when monitoring to prevent this from happening again.</p> |                                                                                                 |  | 01/09/2025                                             |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/15/2026  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       |                                                                                                                          |                                                                                                 |                            |                                                        |  |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                            |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/10/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOTHER'S BEST CARE FOR ELDERLY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       |                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>1225 S 8TH STREET, LAS VEGAS, NEVADA ,89104</b> |                            |                                                        |  |
| (X4)<br>ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                                                 | (X5)<br>COMPLETION<br>DATE |                                                        |  |
| 0590<br>SS= I                                                             | Rights of Residents; Procedure for Filing -<br>NAC 449.268 Rights of residents;<br>procedure for filing grievance, complaint or<br>report of incident; investigation and<br>response. (NRS 449.0302) 1. The<br>administrator of a residential facility shall<br>ensure that: (a) The residents are not<br>abused, neglected or exploited by a<br>member of the staff of the facility, another<br>resident of the facility or any person who is<br>visiting the facility;                                                                                                                                                                                                                                                                                                                                                                                  | 0590                                                  |                                                                                                                          |                                                                                                 | 01/21/202<br>5             |                                                        |  |
| 0740<br>SS= D                                                             | Residents Requiring Indwelling Catheter -<br>NAC 449.272 Residents requiring use of<br>indwelling catheter. (NRS 449.0302) 1. A<br>person who requires the use of an<br>indwelling catheter must not be admitted to<br>a residential facility or be permitted to<br>remain as a resident of a residential facility<br>unless: (a) The resident is physically and<br>mentally capable of caring for all aspects of<br>the condition, with or without the assistance<br>of a caregiver; (b) Irrigation of the catheter<br>is performed in accordance with the<br>physician ' s orders by a medical<br>professional who has been trained to<br>provide that care; and (c) The catheter is<br>inserted and removed only in accordance<br>with the orders of a physician by a medical<br>professional who has been trained to insert<br>and remove a catheter. | 0740                                                  |                                                                                                                          |                                                                                                 | 01/21/202<br>5             |                                                        |  |