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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER'S BEST CARE FOR 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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual state licensure survey and complaint investigation completed in your facility on 03/11/2025, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities 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 nine. Nine resident files and four employee files were reviewed. The facility received a grade of B. There was one complaint investigated. Substantiated Complaint #NV00073303 was substantiated. (See Tag's Y0174 and Y0178). The investigation of Complaint included: Observation of cockroaches in multiple areas of the facility, clutter and debris inside and outside the facility and roof damage in multiple areas of the facility. Interviews were conducted with residents, caregivers, a pest control company and the Administrator. Document Review included a review of pest control services agreement, medication policy and incident reports. 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 investigation, 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: KAREN M. TATLONGHARI, RFA | Title: Administrator | Date: 03/27/2025

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.

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0174 SS= F	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure cockroaches were not present in the facility. Findings include: On 03/11/25, in the morning, German cockroaches were observed both dead and alive in multiple rooms of the home, which included the kitchen, common areas, resident rooms, resident drawers, closets and bathrooms. On 03/11/25, at 9:04 AM, Resident #7 and Resident #8 indicated they had seen multiple cockroaches in the home, which included their bedrooms. On 03/11/25 at 9:15 AM, Resident #1 and Resident #6 revealed they find cockroaches in their drawers and on their personal items. On 03/11/25, at 9:20 AM, Resident #5 indicated they find cockroaches in their room, in their clothing drawer and sometimes on them in bed. When the drawer was opened the cockroaches scattered. R5 had to put lids on top of their drinks because the cockroaches would get into the drinks if left uncovered. On 03/11/25, 9:30 AM, a Caregiver acknowledged there was a problem with cockroaches throughout the facility. On 03/11/25, at 9:50 AM, the Administrator confirmed the facility had an issues with cockroaches throughout the facility since December 2024, which included resident rooms and the kitchen. The facility had a contract with a local pest control company which documented treatment of German cockroaches, however the cockroach issue was still on going. Severity: 2 Scope: 3 Complaint #NV00073303	0174	There is a service contract in place for Pest Control which was shown to the Surveyor at the time of the Survey. Regular general pest control service was conducted on 03/15/2025 and a follow up service done 03/26/2025. We also try to eliminate roaches by manually spraying at night. In addition, cluttered boxes in the 2 front rooms were cleared on the day of the survey. All cluttered areas in Resident's room, common areas and patio area were cleared and kept. Resident's drawers were taken out one by one, cleaned and sprayed. To ensure that this is maintained, we will continue the Pest Control Services and make sure not to store cardboard boxes in resident's rooms and inside the premises. Administrator will constantly monitor the cleanliness and order of the inside and outside of the facility and keep the Pest Control service to hopefully prevent the re-occurrence of this deficiency. Completed 3/16/2025	03/26/2025

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0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the interior and exterior of the home were well maintained and free of debris and clutter. Findings include: The following were observed in the facility. -Multiple boxes of clothing and other accessories were observed stored throughout the backyard. -Large amounts of debris and clutter were observed in commons areas and in the kitchen of the facility. -A room shared by multiple residents, had large amounts of debris and unidentified clutter and was unkempt. -A resident room was observed as a partial storage area for the facility for miscellaneous medical equipment, oxygen canisters and card board boxes. -The ceiling in the living room was cracked and was sinking towards the floor, and was held together with tape. -The ceiling in a restroom was cracked and was sinking towards the floor, and was held together with tape. On 03/11/25, at 9:30 AM, a resident indicated the facility used their room to store items that would not fit anywhere else in the home. On 03/11/25, at 9:39 AM, a resident indicated they had little space due to large amounts of clutter and debris stored in their room by another resident. On 03/11/25, in the morning, a Caregiver confirmed there were multiple boxes of supplies and clothes stored in the backyard that were awaiting removal. On 03/11/25, in the morning, the Administrator confirmed there were large amounts of items stored by residents, in residents' rooms that needed to be removed or relocated. The Administrator confirmed there were cracked ceilings, in need of repair, in the living room and restroom.	0178	All cluttered areas in the patio, kitchen area, and resident's rooms were right away removed and arranged to where it will not be cluttered. Residents' drawers were taken out one by one, cleaned and sprayed. This was completed on 03/16/2025. The ceiling in the living room and in the back bathroom were fixed so it doesn't look cracked and sinking towards the floor. Completed on 3/23/2025 Administrator will continue to monitor the cleanliness and order inside and outside of the facility to prevent this deficiency from re-occurring.	03/23/2025

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	Severity: 2 Scope: 3 Complaint #NV00073303			
1600 SS= C	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104) 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and	1600	Preferred Pronoun Form was right away created and placed on resident's files. To ensure that this deficiency does not occur in the future, Administrator will make sure that this form is part of the admission packet. Completed 03/11/25	03/11/2025

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	(III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on record review and interview, the facility lacked updated policies and procedures addressing the residents preferred pronoun, gender expression and sexual orientation for 9 of 9 residents. Findings include: A review of the resident records revealed the facility lacked updated forms which included a process and procedure to document the resident's gender identification or expression in their medical/resident/patient records. There were nine residents files that did not include documentation of preferred pronoun, gender expression and sexual orientation. On 03/11/25 in the morning, the Administrator confirmed there was no documentation of preferred pronoun, gender expression and sexual orientation and had not added this information to their admission documents for all residents who resided at the facility. Severity: 1 Scope: 3			
1825 SS= F	Designation/Training persons for IC Program - NAC 449.0109 Designation and training of person responsible for infection control. 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare	1825	E1 who is the secondary infection control person and E2 who is the primary infection control person for the facility having no approved training took the training class thru CDC which is the approved organization for Infection Control Training. E1 and E2 both completed the 15-hour course for Infection Control which was completed on 03/25/25. Administrator will continue to monitor employee files to make sure that all required trainings are met and are not expired to prevent re-occurrence of this deficiency.	03/25/2025

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	Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and secondary infection control staff completed 15 hours of infection control training annually from an approved organization (Employees #1 and #2). Findings include: Employee #1 (E1) E1 was hired as a Caregiver on 12/01/01. E1 was designated the secondary infection control person for the facility. E1's file lacked documented evidence of 15 hours of annual infection control training regarding the control and prevention of infections from an approved organization. Employee #2 (E2) E2 was hired as the Administrator on 09/01/98. E2 was designated the primary infection control person for the facility. E2's file lacked documented evidence of 15 hours of annual infection control training regarding the control and prevention of infections from an approved organization. On 03/11/25 in the afternoon, the Administrator acknowledged E1 and E2 did not receive 15 hours of annual infection control training regarding the control and prevention of infections from an approved organization. Severity: 2 Scope: 3			

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1840 SS= D	UNL Caregiver Training - R063-21 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 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 4 employees received infection control training through a nationally recognized organization. (Employee #4) Findings include: Employee #4 (E4) E4 was hired on 01/27/15 as a Caregiver. E4's record lacked documented evidence of infection control and prevention training through a nationally recognized organization. On 03/11/25 in the morning, the Administrator acknowledged the in-service infection control and prevention training for Employees #4 was not through a nationally recognized organization and acknowledged the requirement for the infection control and prevention training should be through a nationally recognized organization. Severity: 2 Scope: 1	1840	Both E3 and E4 who did not have infection control training thru a nationally recognized organization both took the Infection Control Training for Unlicensed Caregiver offered by HCQC. Training completed on 03/25/25. Administrator will continue to monitor employee files to make sure that all required trainings are met and are not expired to prevent the re-occurrence of this deficiency.	03/25/2025