

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8683	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2025
NAME OF PROVIDER OR SUPPLIER MASTER CARE GROUP HOMES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6562 W. MESA VISTA, LAS VEGAS, NEVADA ,89118		
(X4) ID PREFIX TAG RFG 0001- Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG RFG 0001- Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: MARIA T N ACOBA Title: Administrator
REPRESENTATIVE'S SIGNATURE

Date: 11/22/2025

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8683	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2025
NAME OF PROVIDER OR SUPPLIER MASTER CARE GROUP HOMES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6562 W. MESA VISTA, LAS VEGAS, NEVADA ,89118		
(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 survey completed at your facility on 11/12/25. The facility is licensed for five Residential Facility for Group beds for individuals with Alzheimer's disease, Category II residents. The census at the time of the survey was five. Five resident files and four employee files were reviewed. The facility received a grade of A.			
Y 0557 SS= D	NAC 449.262 and R043-22 Provisions of dental, optical and hearing care and social services; report of suspected abuse, neglect or exploitation; restriction on use of restraints, confinement or sedatives. 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or (c) Provide sedatives to a resident unless that sedative has been prescribed for that resident by a	Y 0557	A) Immediately after the survey conducted on 11/12/2025; Administrator gathered all the caregivers; the owner of the facility and specify to them that bedrails are not supposed to be up as per regulations as it is considered a restraint specially to residents that that don't have the ability to put the bedrails down on their own. Exhibit "A" TAG Y 0557 is hereto attached as evidence that said facility complied with said defficiency. B) Administrator should randomly do rounds and observed if the staff are doing the right things and retrained them whenever necessary. C) Administrator should monitor for compliance. D) Person responsible: Administrator E) Completion date: 11/22/2025	11/22/2025

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8683	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2025
NAME OF PROVIDER OR SUPPLIER MASTER CARE GROUP HOMES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6562 W. MESA VISTA, LAS VEGAS, NEVADA ,89118		
(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
	physician, physician assistant or advanced practice registered nurse to treat specific symptoms. A caregiver shall make a record of the behavior of a resident who has been prescribed a sedative. Inspector Comments: Based on observation and interview, the facility failed to ensure bed rails were not used as a restraint for 1 of 5 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 01/01/2024 with diagnosis of dementia. On 11/12/25 in the morning, R2 was observed lying in bed, with full bed rails up on both sides of the bed. R2 was physically unable to lower or raise the bedrails without assistance from staff. R2 was not physically or cognitively able to use the bed rails to reposition in bed without assistance. On 11/12/25 in the morning, R2 was nonverbal and unable to communicate the reason they had bedrails. R2's file documented R2 was bed fast with an expired bed fast waiver. The facility had obtained a waiver shortly after the survey. On 11/12/25 in the morning, the Owner/Caregiver verbalized R2's bed rails helped to keep R2 in bed when staff were providing care and repositioning R2 every two hours. The Owner/Caregiver acknowledged the bed rails should not be used as a			

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8683	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/12/2025
NAME OF PROVIDER OR SUPPLIER MASTER CARE GROUP HOMES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6562 W. MESA VISTA, LAS VEGAS, NEVADA ,89118		
(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
	restraint and should be removed. Scope:2 Severity: 1			