

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 A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2025	
NAME OF PROVIDER OR SUPPLIER BECKY'S HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 4055 CLOUD NINE LANE, LAS VEGAS, NEVADA ,89115			
(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 survey and Complaint Investigation completed at your facility on 07/28/2025. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons Category I and Category II residents with a Mental Illness endorsement. The census at the time of the survey was six. Six resident files and three employee files were reviewed. Provided guidance on Legionella related information from the Infection Prevention Team. Facility was provided information regarding specific items still needing to be submitted to the Infection Prevention Team to ensure compliance and to reach out to the Team for any questions to assist. The facility received a grade of A. There was one complaint investigated. Unsubstantiated: Complaint #NV000744289 was unsubstantiated. No regulatory deficiencies could be identified. The investigation of the Complaint included: Observation of residents in the facility. Interviews were conducted with the residents, caregivers and the Administrator. Record Review of six records, which included the resident of concern. 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. There were no regulatory deficiencies identified. No action necessary. Please retain a copy for your records.	0000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name:
REPRESENTATIVE'S SIGNATURE

Title:

Date:

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.