STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	**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
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
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	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 0817/26. 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 four. Four resident files and three employee files were reviewed. The facility received a grade B.			
Y 0074 SS= E	1. An applicant for a license to operate a facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day, residentialfacility for groups or home for individual residential care must receivetraining to recognize and prevent the abuse of older persons before a licenseto operate such a facility, agency or home is issued to the applicant. If anapplicant has completed such training within the year preceding the date of theapplication for a license and the application includes evidence of thetraining, the applicant shall be deemed to have complied with the requirementsof this subsection. 2. A licensee who holds alicense to operate a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home for individualresidential care must annually	Y 0074	Based on record review and findings from the 8/17/26 survey, the facility has confirmed that 1 of its 3 employees failed to complete an annual Elder Abuse training (Employee #3). In response to this citation, the employee/owner completed an annual Elder Abuse recertification training on 8/25/2026 through the ADSD website. After careful diligence and document research, E3 also found that she took the same training last 02/18/2026 at Abakada Academy. Misplaced certificate was found and retrieved from her employee documents (please see attached). CORRECTIVE ACTION: Going forward, RFA to ensure that annual Elder Abuse Training are monitored through a employee checklist of documents and their corresponding renewal dates found in every employee file. RFA to ensure that timely requests/reminders for renewal will be sent to all employees before training certificates expire.	08/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	**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
	receive training to recognize and prevent theabuse of older persons before the license to operate such a facility, agency orhome may be renewed. 3. If an applicant orlicensee who is required by this section to obtain training is not a naturalperson, the person in charge of the facility, agency or home must receive thetraining required by this section. 4. An administrator or otherperson in charge of a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home forindividual residential care must receive training to recognize and prevent theabuse of older persons before the facility, agency or home provides care to aperson and annually thereafter. 5. An employee who willprovide care to a person in a facility for intermediate care, facility forskilled nursing, agency to provide personal care services in the home, facilityfor the care of adults during the day, residential facility for groups or homefor individual residential care must receive training to recognize and preventthe abuse of older persons before the employee provides care to a person in thefacility, agency or home and annually thereafter. 6. The topics of instructionthat must be included in the training required by this section must include,without limitation: (a) Recognizing the abuse ofolder persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; (b) Responding to reports ofthe alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; and (c) Instruction concerning thefederal, state and local laws, and any changes to those laws, relating to:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	**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
	(1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agenciesto provide personal care services in the home, facilities for the care ofadults during the day, residential facilities for groups or homes forindividual residential care, as applicable for the person receiving thetraining. 7. The facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day,residential facility for groups or home for individual residential care isresponsible for the costs related to the training required by this section. 8. The administrator of afacility for intermediate care, facility for skilled nursing or residentialfacility for groups who is licensed pursuant to chapter 654 ofNRS shall ensure that each employee of the facility who provides care toresidents has obtained the training required by this section. If anadministrator or employee of a facility or home does not obtain the trainingrequired by this section, the Division shall notify the Board of Examiners forLong-Term Care Administrators that the administrator is in violation of thissection. 9. The holder of a license tooperate a facility for intermediate care, facility for skilled nursing, agencyto provide personal care services in the home, facility for the care of adultsduring the day, residential facility for groups or home for individualresidential care shall ensure that each person who is required to comply withthe requirements for training pursuant to this section complies with suchrequirements. The Division may, for any violation of this section, takedisciplinary action against a facility, agency or home pursuant to NRS 449.160and 449.163. Inspector Comments: Based on record			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	**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
	review and interview, the facility failed to ensure 1 of 3 employees completed annual Elder Abuse training (Employee #3). Findings include: Employee #2 (E2) E2 was hired on 06/01/26 as an Owner/Caregiver. E2's file lacked documented evidence of annual Elder Abuse training in 2026. On 08/17/26 in the afternoon, the Owner acknowledged E2 did not attend Elder Abuse training annually and should have. Severity: 2 Scope: 2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
Y 0102 SS= F	NAC 449.200 and R043-22 (d) The health certificates required pursuant to Chapter 441A of NAC for the employee. Inspector Comments: Based on record review and interview, the facility failed to ensure an annual tuberculin (TB) test was conducted for 2 of 3 employees (Employee #2, and Employee #3). Findings include: Employee #2 (E2) E2 was hired on 06/0/26 as a Caregiver. E2's employee file documented a one-step last completed on 06/06/25 with a negative result, and second step TB completed on 06/18/25 with a negative TB result. E2's employee file lacked documented evidence of an annual TB test. Employee #3 (E3) E3 was hired on 01/10/23 as a Owner/caregiver. E3's employee file documented a one-step last completed on 06/03/24 with a negative result, and second step TB completed on 06/10/24 with a negative TB result. E3's employee file lacked documented evidence of an annual TB test. On 08/17/26 in the afternoon, the Owner acknowledged the lack of documentation of an annual tuberculin (TB) test for E2 and E3. Severity: 2 Scope: 3	Y 0102	Based on record review and findings from the recent survey, the facility has confirmed the expirations and/or lack of an annual tuberculin (TB) retests for 2 of its 3 employees (Employee #2 & Employee #3). In response to this deficiency, both Employee #2 & Employee #3 underwent TB screenings. E2 has submitted a negative test result completed last 8/26/2026 from her MD office. E3 also went to see her MD 8/26/2026 at UNLV for a QuantiFERON TB test screening. However, as of this writing, results are still pending. E3 called the MD office and confirms that results will be available earliest today 8/28/2026 or latest by Monday 8/31/2026. RFA to send the results as soon as they become available. CORRECTIVE ACTION: Going forward, RFA will ensure that annual TB tests are monitored through a employee checklist of documents and their corresponding renewal dates found in every employee file. RFA to ensure that timely requests/reminders for renewal will be sent to all employees before TB tests expire.	08/26/2026
Y 0172 SS= F	NAC 449.209 2. Containers used to store garbage outside of the facility must be kept	Y 0172	Based on ocular findings and interview during the survey, the facility acknowledged that premises were not clean and well maintained. During the survey, the inspector observed the following in the backyard: - metal hospital bed - soiled twin mattress - large wooden coffee table - 4 moving dolly's	08/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. 4. To the extentpracticable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 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.		- arm chair with flowers - wooden bedside table - 3 ladders (2) of ladders are leaned against the retaining wall and present safety/potential elopement risk - toxic chemicals: (three cans of waterproofing protector, one gallon paint container, two 5-gallon buckets of used white paint) - worn/weathered broken wooden slat in the seat of a red patio bench-safety hazard - ceramic flooring tiles - wheel barrow - lawn chair - box of various clothing items from a prior resident - electric wheelchair - old construction debris alongside exterior grey storage shed - unsecured leaf blower with orange extension cord - discarded "hoveraround" battery charger. In response to this citation, all aforementioned items including all other clutter have been cleared and removed. The rest of the backyard area including the sideyards were cleaned and cleared of any potential safety/potential hazards to the residents. CORRECTIVE ACTION: Going forward, RFA to conduct regular ocular inspection of the facility's backyard including both sideyards of the facility and coordinate with E2/owner any visible clutter or obstacles that impede free movement of residents who use the area for activities such walking, gardening, relaxation or morning excercise. Hazardous items such as unused DMEs (wheelchairs, bariatic beds, walkers, mattresses etc) will be returned to concerned agencies and cleared from the walkways. These items can also be safely stored and locked inside the storage shed while waiting for them to be picked up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	Inspector Comments: Based on observation and interview, the facility failed to ensure the premises were clean and well maintained. Findings include: On 08/17/26 in the morning, this inspector observed the following in the backyard: - metal hospital bed - soiled twin mattress - large wooden coffee table - 4 moving dolly's - arm chair with flowers - wooden bedside table - 3 ladders (2) of ladders are leaned against the retaining wall and present safety/potential elopement risk - toxic chemicals: (three cans of waterproofing protector, one gallon paint container, two 5- gallon buckets of used white paint) - worn/weathered broken wooden slat in the seat of a red patio bench-safety hazard - ceramic flooring tiles - wheel barrow - lawn chair - box of various clothing items from a prior resident - electric wheelchair - old construction debris alongside exterior grey storage shed - unsecured leaf blower with orange extension cord - discarded "hoveraround" battery charger On 08/17/26 in the afternoon, the Owner acknowledged the premises had not been well maintained and the items in the backyard needed to be cleaned up. Severity: 2 Scope: 3			
Y 0620 SS= E	NAC 449.2702 and R089-24 4. Except as otherwise provided in this	Y 0620	Based on observation, interview and record findings, the facility has confirmed the lack of medical exemption of 1 of its 4 residents (Resident #1). Findings include: Resident #1 has been a resident of the facility since 10/08/22 with diagnoses including	08/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	section and NAC 449.2736 and 449.275, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; (d) Requires skilled nursing or other medical supervision on a 24-hour basis; (e) Requires gastrostomy care; (f) Requires vacuum-assisted wound closure therapy; (g) Requires dialysis, if the person is unable to leave the facility to obtain dialysis services; (h) Suffers from a serious staphylococcus infection or other serious infection; or (i) Suffers from any other serious medical condition or requires care not described in NAC 449.2712 to 449.2734, inclusive. 5. A residential facility that provides care to persons with Alzheimer's disease or other severe dementia, as described in paragraph (a) of subsection 2 of NRS 449.1845, may admit or retain a resident who requires confinement in locked quarters. 6. If a governmental entity with jurisdiction, including, without limitation, a local board of health, a local health officer, the Division, the Chief Medical Officer or the Centers for Disease Control and Prevention of the United States Department of Health and		schizophrenia. R1's file revealed a bedfast medical exemption dated 08/03/23 and that no current bedfast medical exemption approved by HCQC till recent. In response to this deficiency, RFA submitted and completed an application for a medical exemption (bedfast waiver) for R1 and has been approved on 8/25/2026 persuant to NAC 449.2736. We have submitted along with the application an inidividualized plan of care for R1 at the facility alongside a POC from the homehealth agency. CORRECTIVE ACTION: Going forward, RFA to ensure that R1's medical needs will continue to be provided and met at the facility given R1's current medical condition of being bedfast. Facility will continuously update R1's personalized plan of care as deemed fit and in conjuction with the homehealth agency's medical plan of care. RFA to assess R1's level of care requirements and will consult with the homehealth agency's IDG in view of another medical exemption application with the Bureau next year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	Human Services, declares the existence of an epidemic or pandemic, a residential facility located in the area in which the epidemic or pandemic is occurring may permit a resident suffering from a serious infection to remain a resident if the resident does not have symptoms that require a higher level of care than the residential facility is capable of providing. 7. A person may not reside in a residential facility if the person's physician or the Bureau determines that the person does not comply with the requirements for eligibility. 8. As used in this section, "restraint" means: (a) A psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms; (b) A manual method for restricting a resident's freedom of movement or the resident's normal access to his or her body; or (c) A device or material or equipment which is attached to or adjacent to a resident's body that cannot be removed easily by the resident and restricts the resident's freedom of movement or the resident's normal access to his or her body. Reference - R089-24 Sec. 9. "Bedfast" means: 1. Incapable of changing his or her position in bed without the assistance of another person; or 2. Immobile.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	**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
	Inspector Comments: Based on observation, interview and record review, the facility failed to obtain a medical exemption to maintain a resident who was bedfast for 1 of 4 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 10/08/22 with diagnoses including schizophrenia. On 08/17/26 in the morning, R1 was observed alert and lying in bed in an upright position. R1 indicated they were unable to demonstrate the ability to turn from side to side in bed without assistance due to physical issues. R1 indicated needing full assist adjusting in bed. On 08/17/26 in the afternoon, the Owner confirmed R1 required full assistance to reposition in bed or to complete any activities without assistance. Review of R1's file revealed a bedfast medical exemption dated 08/03/23. There was no current bedfast medical exemption approved by the Bureau in R1's file. On 08/17/26 in the afternoon during the exit, the Owner confirmed the facility had not submitted an application to renew a bedfast medical exemption for R1. Severity: 2 Scope: 2			
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	Y 0878	Based on record review and findings, the facility confirmed erroneous entry on its MAR for 1 of its 4 residents (Resident #1). It was found that R1 was taking Risperidone 0.5 milligrams (MG), given by mouth twice daily. On 08/17/26 in the morning, the August 2026 Medication Administration Record (MAR) erroneously documented R1 received Risperidone 1 mg once daily in the morning from August 1 through 17 of 2026. In response to this citation, Owner/E2 emended the error entry from 1mg to 0.5mg in the August 2026 MAR for R1. An	08/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	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 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		emendation was done to reflect the correct dosage of the medication on the MAR moving forward (please see attached). CORRECTIVE ACTION: RFA to conduct a medication review for R1 and all other residents at the facility to ensure accurate entries in the MAR corresponding to the "Five Rights" of medication administration. RFA to continue to prepare MAR on a monthly basis. E2/owner to promptly advise any discontinued or new medications ordered by the providers in order to reflect such changes on the MAR.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	observation, interview and record review, the facility failed to ensure medications were given in accordance with physician's orders for 1 of 4 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 10/08/22 with diagnosis including schizophrenia. Physicians orders dated 07/21/26 documented Risperidone, 0.5 milligrams (MG), take by mouth twice daily. On 08/17/26 in the morning, the August 2026 Medication Administration Record (MAR) documented R1 received Risperidone 1 mgs once daily in the am from August 1 through 17 of 2026. On 08/17/26, the Owner acknowledged the Risperidone was not administered to R1 in accordance with physician's orders. Severity: 2 Scope: 1			
Y 0930 SS= F	**NAC 449.2749** **Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.** 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any	Y 0930	Based on interview and record findings, the facility confirmed the lack of a tuberculosis (TB) screening test for (Resident #1); and the facility failed to obtain a Physician Placement Determination for 3 of its 4 residents (Residents #1, #2 and #4). In view of this citation, we have obtained a copy of R1's TB test screening showing a Negative test result done last 2/5/2026 (please see attached). Furthermore, we have also obtained Physician Placement Determination for R1 (8/21/2026) R2 (8/5/2026) and R4 (7/20/2026) (please see attached). CORRECTIVE ACTION: Going forward, RFA to ensure that Placement Determination Determination are obtained prior to resident admission enabling proper medical evaluation that our facility setting is appropriate for a potential resident's	08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him. (c) A statement of the resident's allergies, if any, and any special diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.		individual care needs. As part of the State's regulatory requirements, this document will ensure that the facilty prevents improper placement of residents while providing reassurance and peace of mind among the family.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	(f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i)The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	the facility. 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death. 3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau. Inspector Comments: Based on interview and record review, the facility failed to the facility failed to ensure a two step tuberculosis (TB) screening was completed for 1 of 4 residents (Resident #1); and the facility failed to obtain a Physician Placement Determination for 3 of 4 residents (Resident #1, #2, and #4,). Findings include: Resident #1 (R1) R1 was admitted to the facility on 10/08/22, with diagnoses including schizophrenia.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	On 08/17/26 a review of R1's medical record revealed a two step TB screening was initiated on 07/15/26. There was no documentation R1 completed a second step TB screening, as there is no evidence of "read date" nor a "positive or negative" finding on the medical record dated 07/15/26. R1's file also lacked a Physician Placement Determination form, and person-centered care plan was last completed on 01/05/25. Resident #2 (R2) R2 was admitted to the facility on 01/27/20, with diagnoses including atrial fibrillation, cognitive communication deficit, anxiety, and cardiac pacemaker. R2's file lacked a Physician Placement Determination form. Resident #4 (R4) R4 was admitted to the facility on 04/04/25, with a diagnosis including senile degeneration of the brain. R4's file lacked a Physician Placement Determination form. On 08/17/26 in the afternoon, the Owner acknowledged a current TB, Physician Placement Determination, and Person-Centered Care Plan was not obtained for R1, and the Physician Placement Determination was not completed for R2 and R4. Severity: 2 Scope: 3			
Y 1825 SS= E	**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:	Y 1825	Based on record review and findings, the facility confirmed the lack of a secondary infection control designee completing 15 hours of infection control training (Employee #2) at home. CORRECTIVE ACTION: In response to this deficiency, E2/owner has been designated as secondary designee responsible for the prevention and control of infections at the facility at all times. E2/owner underwent infection prevention and control training with CDC Train and completed the 15 hours	08/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	(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 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 secondary infection control designee completed 15 hours of infection control training (Employee #3). Findings include: Employee #3 (E3) was hired on 04/01/24 as an Owner/Caregiver. Review of E3's record lacked documented		approved course required pursuant to NAC 449.0109. All certificates will be updated in her employee folder and will be kept in the facility for recordkeeping.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79	A. BUILDING _____ B. WING _____	08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BECKYS HOME CARE	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
	evidence of 15 hours of training concerning the control and prevention of infections from an approved organization. On 08/17/26 in the afternoon, the Owner confirmed E3 was the secondary infection control program designee. The Owner acknowledged that the required infection control and prevention training had not been completed for E3. Severity: 2 Scope: 2			