Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7876	A. BUILDING _____ B. WING _____	12/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF MESQUITE	780 WEST SECOND SOUTH, MESQUITE, NEVADA ,89027

(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 conducted in your facility on 12/12/17. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for 15 Residential Facility for Group beds which provide assisted living services for elderly and disabled persons, Category I and II residents. The census at the time of the survey was 15. Ten resident files were reviewed and ten 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		
0885	449.2742(9) - Medication / Destruction - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregivers and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation and interview, the facility failed to ensure 2 of 15 residents' medications were destroyed after they were discontinued or had expired (Resident #1, #5). Findings include: On 12/12/17, the following was observed: Resident #1 Resident #1's medication inventory revealed ABH 1/12.5/2 milligrams (mg) gel, apply 0.5 milliliters (ml) topically every four to six hours as needed for	0885	How will the specific findings be corrected: the medications listed in the examples have been destroyed or returned to resident family members and are no longer in the facility. What measures or systemic changes will be put into place to ensure the deficient practice does not recur: Day shift staff will review the medications in the medication cart once per month to verify that all medications are current and that any discontinued medications are removed from the cart and disposed of properly. How the corrective action will be monitored: The administrator or administrator designee (house manager) will monitor the corrective action by performing a second review monthly as described above. Title of the person responsible for ensuring the plan of correction is implemented: The Administrator designee (house manager) Date of corrective action: 12/15/2017	12/12/2014

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	agitation. The medication expired on 11/19/17. During an interview in the afternoon, the Employee #2 acknowledged the medication had expired. Employee #2 reported that the expired medication had been administered after its expiration date. Employee #2 advised the medication would be taken out of inventory and destroyed. Resident's medication inventory revealed Ketoconazole Topical 2%, apply to affected areas of scalp. Leave on for ten minutes. Rinse well two times weekly. Review of the December 2017 Medication Administration Record (MAR) revealed the medication was not listed. No reason was documented. Review of the resident's record revealed a physician's order that read, "As of 11/28/17...Discontinue: Ketoconazole Topical 2%...." During an interview in the afternoon, employee #2 acknowledged the medication was not listed on the MAR, no reason was documented, and the medication was discontinued. Employee #2 advised the medication would be removed from inventory and destroyed. Resident #5 Resident #5's medication inventory revealed a dual-pack of Robitussin Cold and Cough and Robitussin Cough. The label on the medication box read, "Robitussin Cold and Cough, take 1 tsp (teaspoon) every 4 hours (hrs) as needed." No label listed Robitussin Cough. Review of the December 2017 MAR revealed Robitussin Cold and Cough 10 mg, administer one teaspoon (10 mg) oral (PO) as needed. There was no Robitussin Cough listed on the MAR. Review of the resident's record revealed a prescription that read, "As of 04/17/17, Robitussin Cold and Cough, take 1 tsp every 4 hrs as needed for cough and cold not to exceed 10 tsp in 24 hrs..." There was no prescription for Robitussin Cough. Employee #1 acknowledged there was no prescription for the Robitussin Cough. During an interview in the afternoon, employee #1 acknowledged there was no label for Robitussin Cough, the medication was not on the MAR, and there was no prescription for the medication. Employee #1 advised they would take the medication out of inventory and destroy it. Resident's medication inventory revealed a loose pill in the resident's dual-pack of Robitussin Cough			

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	and Cold and Robitussin Cough box. Employee #2 acknowledged the loose pill. Employee #2 advised they would destroy the pill. Resident's medication inventory revealed Debrox 6.5%, instill five drops into affected ear(s) by the ear canal two times a day as needed. Review of the December 2017 MAR revealed the medication was not listed. During an interview in the afternoon, employee #1 reported they can not administer the medication, so they have not opened the package. Employee #1 reported they had been storing the medication for the resident at the request of the son-in-law. Per employee #1, they will discard the medication. Severity: 2 Scope: 1			