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 _____	**07/07/2020**

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 a complaint investigation completed in your facility on 07/07/2020, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 15 Residential Facility for Group beds which provides assisted living services, Category II residents. The census at the time of the survey was six. The sample size was five. There were two complaints investigated. Complaint #61038 was unsubstantiated. Allegation #1 - The facility failed to provide adequate care to prevent a resident from declining was unsubstantiated based on Resident #1 was on hospice due to a fatal diagnosis. Allegation #2 - The facility failed to provide meals according to the resident's diagnosis was unsubstantiated based on Resident #1 was not on a special diet. Allegation #3 - The facility failed to give medications with food was unsubstantiated based on the hospice nurse indicated Resident #1's medications were not ordered to take with food. Allegation #4 - The facility failed to provide adequate supervision resulting in a fall was unsubstantiated based on proper fall precautions were put in place. Allegation #5 - The facility failed to provide food and water to a resident resulting in dehydration was unsubstantiated based on the hospice nurse indicated the resident lost the ability to swallow and was end of life. The investigation into the allegations included: Observations of meal preparation, furniture set-up in the facility, care provided to the residents, and staff interactions with residents. Interviews with three residents, the House Manager, Cook, Marketing Director, Administrator and the hospice nurse. Record review/clinical record review of five resident files including the resident of concern, hospice record, incident reports, physician orders, and the Medication	0000		

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

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 _____	**07/07/2020**

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
	Administrator Record. Complaint #61171 was unsubstantiated. Allegation #1 - The facility staff failed to wear masks and allowed visitors in without taking temperatures was unsubstantiated based on observations of all staff wore masks and inspectors temperatures were taken upon arrival. Allegation #2 - The facility failed to follow physician's orders for a resident's sleep medication was unsubstantiated based on the Medication Administrator Record matched the physician's order. Allegation #3 - The facility failed to provide food and water to a resident was unsubstantiated based on the hospice nurse indicated the resident lost the ability to swallow and was end of life. Allegation #4 - A resident was drowsy from taking Lorazepam and almost fell asleep at the table was unsubstantiated based on the hospice nurse indicated the resident was prescribed the medication and drowsiness was a side effect. The investigation into the allegations included: Observations of masks worn by staff, temperature checks upon entry, and resident's demeanor in the facility. Interviews with three residents, the House Manager, Cook, Marketing Director, Administrator and the hospice nurse. Record review/clinical record review of five resident files including the resident of concern, hospice record, physician orders, and the Medication Administrator Record. 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 cited. No further action is needed.			