

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9927	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2020
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF HENDERSON MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 GREENWAY RD BLDG A, HENDERSON, NEVADA ,89002		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an initial survey at your facility on 06/25/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is requesting licensure for 20 Residential Facility for Groups beds for elderly and disabled persons and/or persons with Alzheimer's disease and Assisted Living services, Category II residents. The census at the time of the survey was zero. One sample resident file was reviewed and one employee file was reviewed. There were no regulatory deficiencies identified. No further action is required. Please retain a copy of this report for your records.			

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: Title: Date:
REPRESENTATIVE'S SIGNATURE