

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN2521AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2010
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1683 WINCHESTER DR ELKO, NV 89801		
(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) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division 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. This Statement of Deficiencies was generated as a result of an annual grading survey conducted in your facility on 8/5/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a grade of A. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was eight. Eight resident files were reviewed and ten employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000		
Y 103 SS=D	449.200(1)(d) Personnel File - NAC 441A / Tuberculosis NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by:	Y 103		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

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

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN2521AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2010
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1683 WINCHESTER DR ELKO, NV 89801		
(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) COMPLETE DATE
Y 103	Continued From page 1 Based on record review on 8/5/10, the facility failed to ensure that 1 of 10 employees complied with NAC 441A.375 regarding tuberculosis testing (Employee #6 - no TB test) for the protection of residents. This was a repeat deficiency from the 8/17/09 State Licensure survey. Severity: 2 Scope: 1	Y 103		
Y 105 SS=F	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on 8/5/10, the facility failed to ensure 7 of 10 employees met background check requirements (Employees #3 - 7 and #9 - #10, - no State or FBI clearance letters). Severity: 2 Scope: 3	Y 105		
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order NAC 449.2742	Y 878		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN2521AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2010
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1683 WINCHESTER DR ELKO, NV 89801		
(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) COMPLETE DATE
Y 878	Continued From page 2 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician 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. This Regulation is not met as evidenced by: Based on record review and interview on 8/5/10, the facility failed to ensure that 1 of 8 residents received medications as prescribed (Resident #7) and failed to ensure that ordered as needed medications, were available for use for 2 of 8 residents (Resident #3 and #7). Severity: 2 Scope 1	Y 878		
Y 944 SS=A	449.2749(2) Resident File - Discharge Documentation NAC 449.2749 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.	Y 944		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN2521AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2010
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1683 WINCHESTER DR ELKO, NV 89801		
(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) COMPLETE DATE
Y 944	Continued From page 3 This Regulation is not met as evidenced by: Based on record review and interview on 8/5/10, the facility did not provide proper documentation regarding a resident who had been discharged (Resident #9). Severity: 1 Scope: 1	Y 944		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.