

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS2152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/26/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEE HIVE HOMES OF PARADISE VALLEY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3841 E. TWAIN LAS VEGAS, NV 89121</b>		
(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	<p><b>Initial Comments</b></p> <p>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.</p> <p>This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility from 3/28/11 to 4/26/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for ten Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, Category II residents.</p> <p>Complaint #NV00027880:                      -The allegation regarding caregiver training and medication management training was unsubstantiated through record review and interviews with facility staff, family members and residents.                      -The allegation regarding caregivers not speaking English was was unsubstantiated through interviews with facility staff, hospice agencies, family members and residents.                      -The allegation regarding fluctuating water temperature was not substantiated through observation and interviews with facility staff, hospice agencies, family members and residents.                      -The allegation regarding a lack of access to resident hygiene supplies was not substantiated through observation and interviews with facility staff, hospice agencies, family members and residents.                      -The allegation regarding staffing concerns was not substantiated through observation, document</p>	Y 000		

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:  <b>NVS2152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/26/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEE HIVE HOMES OF PARADISE VALLEY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3841 E. TWAIN LAS VEGAS, NV 89121</b>		
(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	Continued From page 1  review and interviews with facility staff, hospice agencies, family members and residents. -The allegation regarding medication not given as prescribed was substantiated. See Tag Y878. -The allegation regarding the facility not following the menu was not substantiated through observation, document review and interviews with facility staff, hospice agencies, family members and residents. -The allegation regarding the facility not having any activities was not substantiated through observation, document review and interviews with facility staff, hospice agencies, family members and residents. -The allegation regarding roaches in the facility was not substantiated through observation, document review and interviews with facility staff, hospice agencies, family members and residents. -The allegations regarding quality of care issues for the residents including toileting/dressing/bathing and marks on the residents were not substantiated through observation, document review and interviews with facility staff, hospice agencies, family members and residents. -The allegation regarding the facility failing to complete incident reports and the physician and family members not notified was not substantiated through observation, document review and interviews with facility staff, hospice agencies, family members and residents. -The allegation regarding the facility not being clean, and not having enough cleaning products was not substantiated through observation, document review and interviews with facility staff, hospice agencies, family members and residents. -The allegation regarding the facility not providing enough linens and the laundry not being completed regularly was not substantiated through observation, document review and	Y 000			

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:  <b>NVS2152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/26/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEE HIVE HOMES OF PARADISE VALLEY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3841 E. TWAIN LAS VEGAS, NV 89121</b>		
(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	<p>Continued From page 2</p> <p>interviews with facility staff, hospice agencies, family members and residents.</p> <p>-The allegation regarding the facility not having a first aid kit was unsubstantiated through observation.</p> <p>#NV00027880 The complaint investigative process was initiated by the Bureau of Health Care Quality and Compliance on 3/28/11.</p> <p>The investigation for the allegation regarding caregiver training and medication management training included:</p> <p>-A review of the medication administration record, staff schedule and employee files revealed all employees giving medication had the required medication management training. The caregiver files contained evidence of caregiver training.</p> <p>The investigation for the allegation regarding caregivers not speaking English included:</p> <p>-Interviews conducted with the owner, caregiver, family members, representatives from two hospice agencies and resident revealed no specific information regarding which caregivers could not speak English.</p> <p>The investigation for the allegation regarding fluctuating water temperature included:</p> <p>-Interviews conducted with the owner, caregiver, family members, representatives from two hospice agencies and resident revealed the water temperature in the facility was fairly constant. None of the aforementioned individuals noted any vast fluctuation in the water temperature.</p> <p>-Onsite investigation and testing of the water</p>	Y 000			

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:  <b>NVS2152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/26/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEE HIVE HOMES OF PARADISE VALLEY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3841 E. TWAIN LAS VEGAS, NV 89121</b>		
(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	<p>Continued From page 3</p> <p>temperature, which did not fluctuate during testing.</p> <p>The investigation for the allegation regarding a lack of access to resident hygiene supplies included:</p> <ul style="list-style-type: none"> <li>-Interviews conducted with the owner, caregiver, family members, representatives from two hospice agencies and resident revealed there were hygiene supplies available for residents.</li> <li>-Observed resident hygiene supplies under the sink in the common bathrooms and in the bathrooms attached to each bedroom.</li> </ul> <p>The investigation for the allegation regarding staffing concerns included:</p> <ul style="list-style-type: none"> <li>-Observation during an onsite visit. Observations verified between three and four caregivers present at the facility.</li> <li>-Review of the facility staffing schedule, pay stubs and timesheets documented the facility employed an appropriate staffing level.</li> <li>-Interviews conducted with the owner, caregiver, family members, representatives from two hospice agencies and resident revealed the facility had enough staff to provide for the needs of the residents.</li> </ul> <p>The investigation for the allegation regarding the facility not following the menu included:</p> <ul style="list-style-type: none"> <li>-Observation during an onsite visit. Observations verified the facility followed the posted menu. The posted menu contained substitutions noted in ink.</li> </ul>	Y 000			

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:  <b>NVS2152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/26/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEE HIVE HOMES OF PARADISE VALLEY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3841 E. TWAIN LAS VEGAS, NV 89121</b>		
(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	<p>Continued From page 4</p> <p>-Interviews conducted with the owner, caregiver, family members, representatives from two hospice agencies and resident revealed the facility followed the posted menu. The facility occasionally made substitutions to the menu. The food served by the facility was good, no problems were noted.</p> <p>The investigation for the allegation regarding the facility not having any activities included:</p> <p>-Observation during an onsite visit. Observations verified the facility conducted activities. The residents were observed to participate in bingo and music time while onsite.</p> <p>-Reviewed the posted activity schedule which documented at least 10 hours of appropriate activities per week.</p> <p>-Interviews conducted with the owner, caregiver, family members, representatives from two hospice agencies and resident revealed the facility provided various activities for the residents.</p> <p>The investigation for the allegation regarding roaches in the facility included:</p> <p>-Observation during an onsite visit. Observations verified no evidence of rodents or pests in the facility.</p> <p>-Interviews conducted with the owner, caregiver, family members, representatives from two hospice agencies and resident revealed no issues or concerns regarding roaches or pests in the facility.</p>	Y 000			

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:  <b>NVS2152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/26/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEE HIVE HOMES OF PARADISE VALLEY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3841 E. TWAIN LAS VEGAS, NV 89121</b>		
(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	Continued From page 5  The investigation for the allegations regarding quality of care issues for the residents including toileting/dressing/bathing and marks on the residents included:  -Observation during an onsite visit. Observations verified all residents appeared to be neatly and appropriately dressed. No odors associated with urine or feces was detected.  -Interviews conducted with the owner, caregiver, family members, representatives from two hospice agencies and resident revealed no issues with quality of care of the residents.  The investigation for the allegation regarding the facility failing to complete incident reports and the physician and family members not notified included:  -Record review documented several incident reports.  -Interviews conducted with the owner, caregiver, family members, representatives from two hospice agencies and resident revealed the facility did complete incident report forms and called the family members and medical personnel when an incident occurred.  The investigation for the allegation regarding the facility not being clean, and not having enough cleaning products included:  -Observations conducted during an onsite visit. Observations revealed the facility was neat and clean. The facility did show multiple cleaning agents and appropriate cleaning supplies.  -Interviews conducted with the owner, caregiver,	Y 000			

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:  <b>NVS2152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/26/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEE HIVE HOMES OF PARADISE VALLEY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3841 E. TWAIN LAS VEGAS, NV 89121</b>		
(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	Continued From page 6  family members, representatives from two hospice agencies and resident revealed no concerns regarding the cleanliness of the facility.  The investigation for the allegation regarding the facility not providing enough linens and the laundry not being completed regularly included:  -Observations conducted during an onsite visit. Observations revealed the facility had several cabinets in the laundry room full of extra linens. Each bed was observed to have linens and a blanket or comforter.  -Interviews conducted with the owner, caregiver, family members, representatives from two hospice agencies and resident revealed the facility had more than enough extra linens. The linens were changed at least once a week and more often if they became soiled.  The investigation for the allegation regarding the facility not having a first aid kit included:  -Observations conducted during an onsite visit. Observations revealed the facility had a first aid kit available with the required components.	Y 000			
Y 878 SS=E	449.2742(6)(a)(1) Medication / Change order  NAC 449.2742 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	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:  <b>NVS2152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/26/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEE HIVE HOMES OF PARADISE VALLEY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3841 E. TWAIN LAS VEGAS, NV 89121</b>		
(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 7  administration of the medication shall: (1) Comply with the order.          This Regulation is not met as evidenced by: Based on record review and interview from 3/28/11 to 4/26/11, the facility failed to ensure 3 of 10 residents received medications as prescribed (Resident #2- Docusate Sodium 100 milligrams (mg) - medication was not onsite; Resident #3 - Risperidone .25 mg; and Resident #7 - Moducare).  Severity: 2 Scope: 2	Y 878			

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