Business Name: BeeHive Homes of Andrews
Address: 2512 NW Mustang Dr, Andrews, TX 79714
Phone: (432) 217-0123

BeeHive Homes of Andrews

Beehive Homes of Andrews assisted living care is ideal for those who value their independence but require help with some of the activities of daily living. Residents enjoy 24-hour support, private bedrooms with baths, medication monitoring, home-cooked meals, housekeeping and laundry services, social activities and outings, and daily physical and mental exercise opportunities. Beehive Homes memory care services accommodates the growing number of seniors affected by memory loss and dementia. Beehive Homes offers respite (short-term) care for your loved one should the need arise. Whether help is needed after a surgery or illness, for vacation coverage, or just a break from the routine, respite care provides you peace of mind for any length of stay.

View on Google Maps
2512 NW Mustang Dr, Andrews, TX 79714
Business Hours

- Monday thru Sunday: 9:00am to 5:00pm

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Families don’t start out wanting to compare care models. Usually there is a moment that forces the conversation. A father loses weight and forgets his blood pressure pills. A mother falls while carrying laundry. A spouse stops driving after getting lost coming home from the grocery store. I have sat at many kitchen tables where the coffee cools while families ask the same question: can we make home work, or is assisted living the safer, saner choice?

There is no single right answer. The better path depends on health conditions, finances, family bandwidth, and what “home” means to the person who needs care. Both assisted living communities and in-home care can deliver excellent support. Both can fail if poorly matched to needs. What follows blends data with hard-won experience, so you can weigh trade-offs with clear eyes and a full heart.

What assisted living really offers, beyond the brochure

The standard brochure lists meals, housekeeping, social activities, and help with activities of daily living like bathing, dressing, and medication reminders. What it cannot capture is structure. Assisted living works by surrounding residents with predictable routines that reduce risk. Breakfast at eight, chair yoga at ten, vitals checked each morning, the mild social pressure of a neighbor knocking on your door.

Most communities tier their services. Base rent covers the apartment and a minimal service package. Care levels add staff hours for tasks like transfers, continence care, and cueing. If your loved one uses a walker, has mild memory loss, and needs help with showers, level 1 or 2 may suffice. If they wake at night, need two-person assists, or have insulin-dependent diabetes, the monthly fee rises as the care plan intensifies.

Memory care is a distinct wing or program within many communities. The environment is intentionally simplified. Fewer decision points, secured courtyards instead of open exits, colors and lighting that reduce sundowning agitation. Staff training matters as much as architecture. Good memory care teams use short, clear prompts, validation rather than correction, and activities geared to preserved abilities rather than deficits. I have seen residents who paced and refused meals on a general assisted living floor move into memory care and gain weight, join rhythm circles, and smile again.

Respite care is another underused tool. Many communities offer fully furnished apartments for short stays, often two to six weeks. It is a safety valve when a caregiver needs surgery, a break, or to test whether community life fits. The respite resident gets the full-service experience without a long commitment, and families get real data instead of guesswork.

The strengths and limits of care at home

Aging in place is not just a policy slogan. The majority of older adults want to stay in their own homes, with familiar neighbors, pets, and routines. With the right support, home care can be efficient and personal. You can hire a caregiver for the exact hours you need, focus on specific tasks, and avoid paying for services you do not use. The home nurse who notices swelling ankles before they become a hospital admission, the bathing aide who knows your mother likes the water barely warm and the lavender towel last, these small things add up to dignity.

The limits are real. In many regions, in-home agencies struggle to staff reliable evening or weekend shifts. If your parent needs help at 11 p.m., you either pay a premium for overnight care or someone in the family covers it. Supervision is intermittent unless you pay for 24-hour care. That means risks like nighttime wandering, kitchen accidents, or missed medications can slip through the gaps. And homes themselves often need adaptation: step-in showers, grab bars, better lighting, lever handles, a ramp instead of stairs. These are solvable problems, but they usually require time, permits, and cash.

Families often underestimate what it takes to manage in-home care. Even with an agency, you become the care coordinator. You approve the schedule, field the call when a caregiver calls out, stock gloves and incontinence supplies, track refills, and wrangle insurance. When it works, you keep the intimacy of home. When it doesn’t, you live inside the logistics.

What the dollars actually look like

Care costs vary widely by region, but national ranges are useful for planning. In many states, assisted living base rent lands between 4,000 and 6,500 dollars per month for a one-bedroom or studio. That often includes utilities, basic housekeeping, two or three meals daily, and light assistance. Care levels add 500 to 2,500 dollars or more, depending on needs. Memory care typically runs 20 to 40 percent higher than general assisted living due to staffing ratios, specialized programming, and secured environments. Private rooms in stand-alone memory care communities can run from 6,500 to 9,500 dollars per month in mid-cost markets, and higher in coastal cities.

In-home care is priced hourly. Nonmedical home care aides often range from 28 to 40 dollars per hour through an agency. Twelve hours a week for errands, bathing, and light meal prep might cost 1,500 to 2,000 dollars per month. The math changes when needs scale. Daily four-hour shifts in the morning and evening can reach 6,500 to 9,000 dollars per month. Live-in arrangements can start around 350 to 450 dollars per day, but state labor laws may require overtime if the caregiver must remain awake at night, and agencies price accordingly. If you need true 24-hour awake care to manage fall risk or nighttime wandering, the bill can exceed 18,000 dollars per month, which often surpasses assisted living plus memory care.

There are hidden costs on both sides. At home, add home modifications, emergency alert systems, transportation, meal services, and your time. Families often spend hours coordinating care, and if that replaces paid work, it has an economic cost even if no cash changes hands. In assisted living, expect one-time community fees, cable or internet add-ons, hair salon charges, and supplies such as briefs or supplements billed separately. Annual rate increases of 4 to 8 percent are common, and care level reassessments can bump the monthly bill when needs change.

Insurance coverage is often misunderstood. Medicare does not pay for long-term custodial care in either setting. It covers medical services like physician visits, hospitalizations, and time-limited home health after an acute event. Long-term care insurance can cover assisted living, memory care, and in-home care if the policy triggers are met, typically needing help with two or more activities of daily living or having a cognitive impairment. Policies vary wildly, so read the elimination period, daily maximums, and inflation riders. Veterans may qualify for Aid and Attendance, which can offset costs by several hundred to over two thousand dollars per month based on wartime service, assets, and income. Medicaid can fund long-term care for those who qualify financially. Some states have waiver programs that pay for in-home supports to delay nursing home placement; others fund assisted living slots. Availability is limited, and waitlists are common.

Health complexity shapes the right fit

The decision pivots on what exactly needs to be managed. If the main challenges are housekeeping, meal preparation, and occasional reminders, in-home care can be beautifully efficient. A part-time aide can run laundry, prepare meals for the week, and cue medications while you keep the rest of the routine intact. Add adult day programs two or three times weekly for socialization and caregiver respite, and many people thrive.

If mobility is limited, the home’s layout matters more than sentiment. I once worked with a retired electrician who loved his split-level house. After a hip fracture, the six steps between the living room and bedroom turned into a daily hazard. We measured, priced a modular ramp and a stair lift, and compared that total to the price of an assisted living studio. He chose to move, not because he liked the idea of community life, but because his stubborn independence made surprise

falls more likely than scheduled help. In assisted living, he could keep his routine without stairs, have help with showers, and still tinker with radios in his room.

Cognitive changes raise a different set of questions. Early memory loss can be supported at home with automatic pill dispensers, door alarms, a simplified kitchen, and regular check-ins from family and aides. But unsafe wandering, repeated kitchen mishaps, or aggressive outbursts can overwhelm a home setting, especially if there are grandchildren in the house. Dedicated memory care units have staff who expect resistance, accept it without judgment, and use proven techniques to lower agitation. They also remove the constant vigilance burden from spouses who have been sleeping with one ear open for years.

Chronic medical needs steer the decision too. Insulin management, heart failure monitoring, oxygen therapy, wound care, and repeated urinary tract infections require vigilance. Some assisted living communities can handle these with on-site nurses and pharmacy partners. Others are strictly social models and call 911 for anything complex. At home, you can pair a nonmedical aide with a visiting nurse under a physician's orders, but that home health nurse is not on call 24/7. If your loved one needs frequent assessments or rapid medication adjustments, a setting with continuous staff presence may be safer.

Social life, autonomy, and how people actually spend their days

Social isolation is as dangerous as many chronic diseases. It raises the risks of depression, cognitive decline, and hospitalization. Home can be a fortress or a prison, depending on how many people come through the door. I have seen clients who lived alone with a cat and a television, and the caregiver's four hours became the day's only conversation. For one woman, we added a twice-weekly senior center program with transport, and her mood lifted within two weeks. She started baking again because she had people to share the brownies with.

Assisted living compresses distance. Friends are across the hall, not across town. Activities can feel silly until someone tries them. Bingo is a social Trojan horse. People who would never sign up for a lecture will wander in for coffee and stay to chat. The dining room's biggest service is not calories, but conversation. That said, community fit is critical. A former teacher may not enjoy a community that skews toward television in common rooms and few lectures or book clubs. A retired mechanic may balk at a place that emphasizes crafts over hands-on tinkering. Tour at mealtimes, not just mid-morning when everything smells like lemon cleaner and looks serene.

Autonomy is about meaningful control, not the absence of help. Many older adults fear that moving to assisted living means staff will dictate their day. Good communities adjust to resident routines. If you prefer a late breakfast and a shower at night, ask specifically whether the staff can honor that. At home, autonomy is easier to protect, but only if the routine is safe. If your father insists on mowing the lawn in July heat and you work an hour away, autonomy collides with risk. A compromise could be a smaller, manageable patio garden at an assisted living community or shifting mowing to a service while keeping other tasks at home.

Safety and the quiet power of design

Homes accumulate hazards over decades: scatter rugs that slide, dim hallways, staircase lighting on a pull chain just out of reach, bathtubs with high sides. A simple home safety assessment by an occupational therapist can uncover low-cost fixes that dramatically reduce falls. Bright task lighting in the kitchen, contrast strips on stair edges, lever door handles, and a comfort-height toilet solve more problems than most gadgets. If dementia is present, reduce visual clutter and reflective surfaces and use clear signage on rooms and drawers.

Assisted living buildings are designed to mitigate those risks from the ground up. Level thresholds, wide hallways, handrails that run the full length of corridors, step-in showers with built-in seats, and emergency pull cords reduce injury. Memory care layouts often use circular walking paths so pacing residents don’t reach dead ends that trigger agitation. Outdoor courtyards with single, secured entry points allow fresh air without elopement risk. These design elements are boring in a brochure and invaluable at 2 a.m.

Emergency response is another piece. In assisted living, a fall often brings a staffer within minutes, not hours. At home, response time depends on who is there and whether the person can use an alert pendant. I have reviewed too many hospital charts that begin with “found on the floor after unknown downtime.” If your loved one resists wearing an alert device, you either staff around that refusal or acknowledge the risk.

What families often overlook until it hurts

Caregiver burnout arrives slowly, then all at once. A spouse does more each month, saying it is no big deal. The sleep debt accumulates. Back pain becomes constant. Patience thins at 4 p.m., just when sundowning begins. During a hospital admission for pneumonia, the spouse’s blood pressure is sky-high, and the nurse quietly asks whether anyone has checked on the caregiver. Respite care exists for a reason. Using it does not signal failure. It is capacity management. Whether you bring in a weekend aide, enroll your loved one in adult day twice a week, or schedule a two-week respite stay in a community once a quarter, those breaks keep home viable.

Families also underestimate how care needs compound. A relative with mild memory loss and stable mobility can tip into nonweight-bearing status overnight with a fracture. The home that worked last week becomes unsafe. Keeping a go-bag, a list of medications, copies of power of attorney documents, and a short one-page “About Me” that covers routines and preferences prepares you for that pivot. In a crisis, every minute you are not hunting for a medication list is a minute you can spend making a better decision.

Another blind spot is the idea that a move will solve entrenched loneliness or family conflict. Assisted living can provide opportunities, but it cannot rewrite personality or relationships. If a parent rejects social invitations now, they may continue to do so in a community. The difference is that with gentle staff nudging, they may try more often. But a family that argues about finances or boundaries will bring those patterns to any setting. Clear roles and written agreements

reduce resentment. Decide who pays bills, who attends medical appointments, who has the final say when opinions differ.

Using respite care strategically

Respite care is not only a break, it is a pilot program. You can test an assisted living or memory care community for fit, observe staff interactions, and see whether your loved one settles after the first few days. Set realistic expectations. The first 72 hours are usually rocky. New smells, new faces, and a new bed unsettle anyone. By week two, routines form. If your loved one refuses group activities, ask staff to start with one-to-one visits or to seat them with conversational tablemates rather than at a large table. If sleep is disrupted, request a familiar blanket and the usual pre-bed snack.

At home, schedule respite on your terms before you are desperate. Start small. A Saturday afternoon caregiver can handle bathing and allow you to run errands or sit in a park with a book. If your loved one pushes back, frame the caregiver as a house helper or a visiting friend rather than a personal aide. People accept support more readily when it preserves their role. “Jasmine comes to help me with the heavy laundry” feels better than “Jasmine bathes me.”

A decision framework you can actually use

When the choices feel overwhelming, narrow them to a few core questions. Agree as a family to revisit monthly for three months. Needs change, and so should the plan.

- What are the top three risks in the current setup, and how will we reduce each within 30 days?
- What specific supports does the person want, accept, and reject right now?
- What is the true monthly budget, including hidden costs and likely rate increases or extra hours?
- Who is on the care team, what are their roles, and what backup do we have for each role?
- What would trigger a move or an increase in care, and who decides when that trigger is met?

Real comparisons from the field

Case one: A 79-year-old widow with arthritis, mild forgetfulness, and a small bungalow. She still drives locally, but grocery bags and tubs are heavy. We put in two grab bars, replaced the tub with a low-threshold shower, and arranged for eight hours per week of in-home care focused on transportation, meal prep, and shower assistance. She also joined the local senior center two mornings weekly. Total monthly outlay: about 1,600 dollars for care plus 200 dollars for the center and rides. Two years later, as arthritis progressed, we added a weekly housekeeping service and a medication dispenser. She stayed home happily until the day she decided she missed other people at dinner and moved by choice.

Case two: An 82-year-old couple, one with Parkinson’s and frequent nighttime falls, the spouse with high blood pressure and chronic back pain. We tried adding a night caregiver three nights a week, then five. The spouse still slept poorly the other nights, worrying. After an ER visit for a fall with a head laceration, we toured assisted living communities that could manage Parkinson’s needs. They chose a one-bedroom unit near the elevator. The resident with Parkinson’s stabilized with routine physical therapy and predictable medication cues. The spouse’s blood pressure normalized within three months.

Case three: A 74-year-old retired teacher with early Alzheimer’s who walked out the back gate twice. The family added door alarms and a GPS watch, but the person disliked wearing it and removed it. We trialed adult day memory programs, which worked during the day but did nothing for evening wandering. After an unplanned police call and a neighbor returning the person at midnight, the family tried a month of memory care respite. The resident resisted at first, then started attending music groups and slept at night. The family opted to extend the stay, not out of convenience, but because the person was eating better and calmer.

How to tour an assisted living or memory care community with purpose

Do not be dazzled by chandeliers. Spend time where care happens. Visit at different times of day, including evenings. Ask about staff ratios on weekends, not just weekdays. Follow an aide on a med pass, at least visually from a distance, to see how they cue without rushing. Read the calendar, then watch whether activities happen as posted. Sit in the dining room next to residents and listen. Are plates cleared quickly, or does everyone wait for one slow eater and get cold food? Tour the memory care garden. Check for shade, seating with arms, and a simple loop path without dead ends. Ask to see a studio at the lowest price point as well as the model unit.

Ask policy questions that matter. How are rate increases determined? What services trigger a new care level? How do you manage residents who refuse showers? Under what situations do you discharge someone to a higher level of care, and how much notice do families get? Request a copy of the resident rights and grievance process. Good communities answer directly and provide written follow-up, not just friendly assurances.

How to build a sustainable in-home plan

Identify the core hours of risk. If falls happen at night, prioritize overnight coverage or technology that detects bed exits and alerts a responder. If meals are the problem, front-load aide hours in late morning and late afternoon to handle breakfast and dinner and prep for the next day. Pair tasks with pleasant rituals: music during bathing, coffee while sorting pills. Invest in equipment that saves backs and reduces injury: a sturdy shower chair, a transfer bench, a handheld shower, a rollator with a built-in seat. Test any new device with an occupational therapist if possible.

Recruit and train the team. If using an agency, request the same two or three caregivers consistently. Provide a one-page profile with routines, favorite foods, conversation topics, and words to avoid. If hiring privately, understand that you become the employer, with payroll taxes, workers' compensation, and backup responsibilities. Consider an outside care manager to coordinate across providers and to spot issues early.

Use your respite early and often. Mark caregiver breaks on the calendar, protect them like medical appointments, and make them restorative. A break spent catching up on paperwork is not a break. Ask a trusted friend to rotate in for social visits that are not task-focused. People accept "come have tea" more readily than "come handle Dad's shower," but both matter.

Memory care is not a failure, it is a specialization

Families sometimes treat memory care as a last resort, but it is simply a setting where everything from paint color to staff training supports brain change. I have watched residents who were labeled "resistant" at home become more relaxed when the world around them made sense again. Doors that blend into the wall reduce exit seeking. Visual menus help residents choose lunch without performance anxiety. Staff offer choices that are both acceptable, such as "blue shirt or green today," and avoid quizzing that triggers shame.

The measure of success is not whether the person "remembers more." It is whether they feel secure, maintain weight, engage at their level, and have fewer distress behaviors. Good memory care focuses on retained abilities and familiar rhythms. A retired baker might smell cinnamon and start kneading dough, even if the end product is symbolic. A former engineer might take pleasure in sorting hardware. The goal is connection, not productivity.

The honest bottom line

Assisted living offers structure, immediacy, and community at a predictable monthly rate that scales with need. It reduces the coordination burden on elderly care families and can stabilize health through routine. Memory care adds an environment and staff skill set designed for dementia. Respite care in these settings gives families breathing room and real-world data about fit.

In-home care offers control, intimacy, and the comfort of familiar surroundings. It scales elegantly for light support and can become expensive or fragile when needs expand, especially overnight. Success at home depends on the house's safety, the availability of reliable caregivers, and honest assessment of family capacity. It keeps personal rhythms intact, which often matters as much as any medical measure.

Start with specifics, not ideals. List the three most important things your loved one wants to keep, whether that is morning coffee on the porch, attending church, or sleeping in. Then list the three risks you must tame. Put real numbers next to real hours of help and real communities, in your zip code, not hypothetical averages. Tour, test, and revisit. Use respite care without apology. Talk openly about money, stamina, and what will trigger the next decision.

You are not choosing between love and duty, or between independence and safety. You are shaping a life that balances cost, care, and comfort as needs change. That balance will look different in January than it does in June, and that is not a mistake. It is the work.

BeeHive Homes of Andrews provides assisted living care
BeeHive Homes of Andrews provides memory care services
BeeHive Homes of Andrews provides respite care services
BeeHive Homes of Andrews supports assistance with bathing and grooming
BeeHive Homes of Andrews offers private bedrooms with private bathrooms
BeeHive Homes of Andrews provides medication monitoring and documentation
BeeHive Homes of Andrews serves dietitian-approved meals
BeeHive Homes of Andrews provides housekeeping services
BeeHive Homes of Andrews provides laundry services
BeeHive Homes of Andrews offers community dining and social engagement activities
BeeHive Homes of Andrews features life enrichment activities
BeeHive Homes of Andrews supports personal care assistance during meals and daily routines
BeeHive Homes of Andrews promotes frequent physical and mental exercise opportunities
BeeHive Homes of Andrews provides a home-like residential environment
BeeHive Homes of Andrews creates customized care plans as residents' needs change
BeeHive Homes of Andrews assesses individual resident care needs
BeeHive Homes of Andrews accepts private pay and long-term care insurance
BeeHive Homes of Andrews assists qualified veterans with Aid and Attendance benefits
BeeHive Homes of Andrews encourages meaningful resident-to-staff relationships
BeeHive Homes of Andrews delivers compassionate, attentive senior care focused on dignity and comfort
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BeeHive Homes of Andrews won Top Assisted Living Homes 2025
BeeHive Homes of Andrews earned Best Customer Service Award 2024
BeeHive Homes of Andrews placed 1st for Senior Living Communities 2025

People Also Ask about BeeHive Homes of Andrews

What is BeeHive Homes of Andrews Living monthly room rate?

The rate depends on the level of care that is needed. We do an initial evaluation for each potential resident to determine the level of care needed. The monthly rate is based on this evaluation. There are no hidden costs or fees

Can residents stay in BeeHive Homes until the end of their life?

Usually yes. There are exceptions, such as when there are safety issues with the resident, or they need 24 hour skilled nursing services

Do we have a nurse on staff?

No, but each BeeHive Home has a consulting Nurse available 24 – 7. if nursing services are needed, a doctor can order home health to come into the home

What are BeeHive Homes' visiting hours?

Visiting hours are adjusted to accommodate the families and the resident's needs… just not too early or too late

Do we have couple's rooms available?

Yes, each home has rooms designed to accommodate couples. Please ask about the availability of these rooms

Where is BeeHive Homes of Andrews located?

BeeHive Homes of Andrews is conveniently located at 2512 NW Mustang Dr, Andrews, TX 79714. You can easily find directions on Google Maps or call at (432) 217-0123 Monday through Sunday 9:00am to 5:00pm

How can I contact BeeHive Homes of Andrews?

You can contact BeeHive Homes of Andrews by phone at: (432) 217-0123, visit their website at https://beehivehomes.com/locations/andrews/, or connect on social media via Facebook or YouTube

Florey Park provides shaded seating and open areas ideal for assisted living and memory care residents during senior care and respite care visits.