Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2179	A. BUILDING: _____ B. WING _____	C 12/04/2020

NAME OF PROVIDER OR SUPPL ER	STREET ADDRESS, CITY, STATE, Z P CODE
BEE HIVE HOMES OF SANTA FE	3838 THOMAS ROAD SANTA FE, NM 87507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROV DER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during an Offsite Complaint survey completed on 12/04/20 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint #NM45361 was substantiated with (1) one deficiency cited.	A 000		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and	A 032	**A 032** **The facility shall ensure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. The facility shall report any and all unusual occurrences in accordance with 7.1.13 NMAC.** **Administrator will train the facilities manager on reporting suspected or known incidents of abuse, neglect, and exploitation. The facility shall hold a staff in-service and re-training regarding suspected cases or known incidents of abuse,neglect, and exploitation.** **The facility will comply with all required documentation regarding investigation of incident reporting in a timely fashion (within 5 business days from occurrence of incident). The facilitie's compliance will include an investigation report, a narrative description of the incident, and a 5-day follow-up. Copies of each document will be maintained at the facility.**	**4.18.2021** **5.7.2021** **4.18.2021**

	(3) plans for further actions in response to the			

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A 032	Continued From page 1 incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) B 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W & 8 B (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor ' s order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division ' s incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau ' s incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next	A 032	**A 032** **The facility shall comply in reporting and investigating all Reportable Incidents with the corresponding Division incident report form. The facility will ensure that any Reportable Incidents are reported in a timely fashion and are received by the incident reporting bureau within 24 hours of an incident or allegation of an incident or next business day of a holiday or weekend. Facility manager and/or administrator will be responsible for monitoring the corrective action to ensure ongoing compliance by investigating any reportable incidents and/or unusual occurrences.**	**4.18.2021**

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A 032	Continued From page 2 business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure for 1 (R #1) of 5 (R #s 1-5) residents whose resident files were reviewed for compliance; that incidents of unusual occurrence (with injury): 1. Were reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend. 2. That an internal investigation was conducted and a follow-up report was submitted to the Licensing Authority within 5 business days from the date of the incident. This deficient practice could likely result in the residents being at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority. The findings are: A. Record Review of R #1's Shift Change Notes dated 03/15/20 to 11/18/20 revealed that on 05/28/20 at 6:50 pm, Direct Care Staff (DCS) noted that R #1 had a [redacted] of unknown origin. B. Record review of Ombudsman Regional Coordinator (ORC) journal notes included in the Department of Health (DOH) Complaint Intake NM#45361 revealed that, on 06/04/20 R #1's [redacted] told the ORC that the facility House Manager (HM) informed [redacted] that [redacted] 20. C. Record review of ORC journal notes	A 032		

	included in The Department of Health (DOH) Complaint			

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A 032	Continued From page 3 Intake NM#45361, revealed that on 06/05/20, the HM told the ORC that: 1. R #1 had a [redacted] that started out as a [redacted] discovered on 05/28/20. 2. Direct Care Staff (DCS #4) should have reported the incident to the family on 05/28/20 and did not. D. Record review of the facility's internal incident reports dated 01/01/20 to 11/30/20 revealed no documentation to show that the 05/28/20 incident of R #1 having a [redacted] of unknown origin was reported to the Licensing Authority. E. On 12/04/20 at 3:32 pm, during the exit interview with the Administrator and HM, the HM confirmed that the 05/28/20 incident where R #1 had a [redacted] from an unknown origin was not self-reported, that the facility did not conduct an investigation, nor did they submit a follow-up report to the Licensing Authority.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other;	A 033		

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A 033	Continued From page 4 (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private	A 033	.	

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A 033	Continued From page 5 correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney;	A 033		

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A 033	Continued From page 6 (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: NMAC 7.8.2.33 D (1) (11) (a) Based on record review and interview, the facility failed to ensure for 1 (R #2) of 5 (R #s 1-5) residents whose incident reports were reviewed for compliance that residents were:: 1. Treated with courtesy, respect, dignity, and compassion. 2. Free from physical and emotional abuse by Direct Care Staff (DCS). This deficient practice could likely resulted in R #2 suffering unnecessary mental/physical distress and increased the potential for the residents to be at risk of being abused. The findings are:	A 033	**A 033** **The facility shall ensure that residents are:** **1) Treated with courtesy, respect, dignity, and compassion.** **2) Free from physical and emotional abuse by Direct Care Staff (DCS).** **The facility shall hold a staff in-service and re-training regarding suspected cases or known incidents of abuse,neglect, and exploitation.** **The facility shall hold a staff in-service on residents rights.** **In-service will include consequences and/or disciplinary action for Direct Care Staff that are mis-treating residents. The facilities manager will ensure on-going compliance by supervising employees and meeting with residents weekly to ensure they’re being treated with respect and dignity.**	**5.25.2021** **6.11.2021**

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A 033	Continued From page 7 A. Record review of Ombudsman Regional Coordinator (ORC) journal notes included in The Department of Health (DOH) Complaint Intake NM#45361 revealed that, on 06/05/20 the House Manager (HM) told the ORC that DCS #4 was fired when she was seen shoving R #2 who has a diagnosis of [redacted] B. On 12/04/20 at 10:00 am, during observation of video footage dated 05/31/21 recorded in the living room revealed the following: 1. Video #1 beginning at 7:54 am: a. R #2 was observed in a recliner in the living room playing with a lamp and lampshade from the table beside [redacted] b. DCS #4 was observed coming from the kitchen and taking the lamp from R #2 and setting it out of [redacted] reach. R #2 said "stop it." Then both R #2 and DCS #4 say something that wasn't clear on the tape. c. R #2 was observed still reaching [redacted] arms toward the lamp and moving [redacted] around. DCS #4 then moved R #2's arm back inside the chair and told R #2 2-3 times to "stop it." d. Then DCS #4 went and got a blanket and threw it on R #2, including covering [redacted] face. 2. Video #2 beginning at 8:17 am: a. R #2 was observed sitting at the edge of the recliner with one of [redacted] b. DCS #4 was observed to enter the camera view from the left with another (unknown DCS) pushing a food cart. DCS #4 could be heard shouting "[Name of R #2], [Name of unknown person] said you are to sit down, why aren't you listening, why aren't you listening." R #2 mumbles (unknown words) and laughs. DCS #4 say "no you are not, you keep getting up." c. DCS #4 then in a loud voice tells R #2 No, No!" while pushing [redacted] back into the recliner	A 033		

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A 033	Continued From page 8 by [redacted] DCS #4 then covers R #2 up with [redacted] blanket again, including [redacted] face and tells R #2 to "take a nap. 3. Video #3 beginning at 8:36 am: a. R #2 was observed sitting with [redacted] on the side of the recliner with [redacted] b. DCS #4 approaches, turns R #2 by the shoulders and in a loud voice is heard saying "No! (while pushing R #2 back into the recliner and putting [redacted] No!, what don't you understand! What don't you understand missy! Do you want to fall and hit your face again?" Resident mumbles "no". c. DCS #4 is then observed to push recliner back in an upright position putting the footrests down with [redacted] Then stop, sit your butt down, where are you trying to go. No, that doesn't even make sense, stop it, and then walks away, Resident can be heard mumbling and possibly saying no in response to DCS #4. Sit down! d. DCS #4 brings a wheelchair and leaves it by R #2's recliner - and walks away again not ensuring R #2 is safely seated in the recliner. R #2 is observed still trying to get out of the recliner. 4. Video #4, dated 08/31/20 beginning at 8:39 am: a. DCS #4 was observed feeding R #2. R #2 was observed reaching down towards the floor with [redacted] between DCS #4's leg and the wheelchair that DCS #4 is sitting in while feeding [redacted] b. DC #4 tells R #2, "That's it, sit back! [Name of R #2] sit back please, sit back, you act like your starving" R #2 says "well I am not". DCS #4 "That is how you are acting." R #2 mumbles unclear words. DCS #4 says "Thank you, like your are starved here."	A 033		

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A 033	Continued From page 9 C. On 12/02/20 at 2:22 pm, during an interview, the House Manager (HM) reported that during and before DCS #4 was terminated, she was trying to deflect and deny the incident happened until she was shown the video. D. On 12/04/20 at 3:35 pm, during an exit interview with the House Manager and Administrator, they confirmed that after they were made aware of the incident: 1. The video was viewed confirming the incident with R #2 did occur as described above. 2. DCS #4 was terminated because she was an experienced employee (Assistant Manager) who should have known better and set a good example to other employees.	A 033		