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Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2211	A. BUILDING: _____ B. WING _____	C 02/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF FARMINGTON 4	508 B N AIRPORT DR FARMINGTON, NM 87401

(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
A 000	Initial Comments The following deficiencies were cited as a result of a Complaint survey completed on 02/05/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake #NM34368 was substantiated with deficiencies cited.	A 000		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC;	A 020		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: BCruzen 052019 | TITLE: Administrator/RN | (X6) DATE: 5/20/19

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A 020	Continued From page 1 (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require	A 020		

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A 020	Continued From page 2 continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in	A 020		

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A 020	Continued From page 3 writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]	A 020		

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A 020	Continued From page 4 This REQUIREMENT is not met as evidenced by: 7.8.2.20 C (1) D (1) Based on record review and interview the facility failed to ensure for 1 (R #4) of 1 (R #4) residents receiving home health services that: 1. A team meeting was convened prior to admitting/retaining residents who have elected to receive home health services. 2. Coordination of care was documented with the home health provider on the Individual Service Plan (ISP). This deficient practice has the potential for residents receiving home health services to be at risk of harm if: 1. A higher level of care and services is needed than the facility would normally provide. 2. The Direct Care (DCS) Staff do not know what services they are to provide and what services the home health agency will provide. The findings are: A. Record review of R #4's file revealed: 1. Record review of the Home Health Visit sheet dated [redacted]/19 revealed that services were restarted on [redacted]/19 2. The last ISP was completed on 10/29/18 and the ISP was not reviewed or revised to include coordination of care between the home health agency and facility when home health services restarted on [redacted]/19. B. During interview the House Manager confirmed that there was no: 1. Team meeting was convened for R #4 prior	A 020 C1/D1	7.8.20 C (1) D (1) Resident #4 was not recieving home health services. The family hired a private paty caregiving company to keep resident company - Residents who do receive home health services: A team comprised of resident and/or POA, home health Clinician, and the house manager will prior to admission to home health service to coordinate care. - Residents on home health services will have all documentation from home health providers in their binder. - House manager to conduct monthly audits of residents binders to ensure compliance.	052019

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A 020	Continued From page 5 to being receiving home health services 2. Documented coordination of care on the Individual Service Plan (ISP).	A 020		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions;	A 025		

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A 025	Continued From page 6 (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 B C (14) (16) Based on record review and interview the facility failed to ensure for 2 (R #s 1 and 4) of 4 (R #s 1-4) residents whose Evaluations/Assessments were reviewed for compliance, that they were: 1. Reviewed and/or updated when there was a change of condition. 2. Updated to include status changes.	A 025	7.8.2.25 BC (14)(16) - Change of Condition: R#1,4 Evaluations were not update/completed when a change of condition occured - House manager to conduct monthly audits on residents binders/charts including online programs and make necessary changes to ensure compliance. - RN to review all evaluations and ISP's, and sign when approved. - House manager to notify RN of new/updated evaluations and ISP to maintain compliance.	052019

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A 025	Continued From page 7 This deficient practice has the potential to negatively affect the health and safety of residents by not receiving needed care and services. The findings are: Findings for R #1: A. Record review of R #1's Evaluation/Assessment dated 10/29/18 revealed it was not updated when: 1. There was a change of condition on [redacted]/18 when the resident was found stiff, in a *fetal position while sitting in her wheelchair.* R #1 was transported to the hospital where she was diagnosed with dehydration, diarrhea, weakness, and fatigue. 2. There was a change in skin condition on 11/22/18 when Direct Care Staff (DCS) #3 discovered a small pressure sore on R#1's tailbone. B. Record review of R#1's Emergency room (ER) discharge orders dated [redacted]/18 revealed that R #1 was diagnosed with dehydration, diarrhea, weakness, and fatigue. C. Record review of R #1's Shift Change Notes dated 11/01/18 to 01/01/19 revealed, that on 11/22/18 DCS #3 discovered a small pressure sore on R #1's tailbone. D. On 02/05/19 at 10:20 am, during an interview with the House Manager, she confirmed that R #1's Evaluation/Assessment was not updated when there was a change in condition on 11/21/18 and 11/22/18. Findings for R #4: E. Record review of R #4's	A 025		

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A 025	Continued From page 8 Evaluation/Assessment dated 08/10/18 revealed it was not reviewed and/or updated when a change in condition occurred and home health services were restarted [redacted]19. F. On 02/05/19 at 2:50 pm, during an interview with the House Manager, she confirmed that R #4's Evaluation/Assessment was not updated when there was a change of condition and home health services were restarted on [redacted]/19.	A 025	7.8.2.26 A(1)(2)(3) ISP not updated when significant change occurs - House manager to update ISP when change occurs. - House manager to notify RN with changes & updated ISP for review and approval. - House manager to review resident charts monthly and make all necessary changes to maintain compliance.	052019
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided;	A 026		

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A 026	Continued From page 9 (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (1) (2) (3) Based on record review and interview the facility failed to ensure that 2 (R #s 1 and 4) of 4 (R #s 1-4) residents whose Individual Service Plan (ISP) were reviewed for compliance: 1. Were reviewed and updated when changes in condition occurred. 2. Included documentation of coordination of care with home health providers. This deficient practice has the potential for residents to be at risk of harm if they do not receive the appropriate care and assistance as changes in their health status occurs. The findings are: Findings for R #1: A. Record review of R #1's ISP dated 10/29/18 revealed:	A 026		

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A 026	Continued From page 10 1. It was not updated: a. When there was a change of condition on [redacted]/18 and the resident was found stiff, in a fetal position while sitting in her wheelchair. R #1 was transported to the hospital where she was diagnosed with dehydration, diarrhea, weakness, and fatigue. b. When there was a change in skin condition on 11/22/18 and the Direct Care Staff (DCS) #3 discovered a small pressure sore on R #1's tailbone. 2. To include coordination of care with the home health provider when she began receiving services from a Home Health provider. B. On 02/05/19 at 10:00 am, during an interview with the House Manager (HM), she confirmed that R #1's ISP: 1. Was not updated: a. When there was a change of condition on [redacted]18 and the resident was found stiff, in a fetal position while sitting in her wheelchair. R #1 was transported to the hospital where she was diagnosed with dehydration, diarrhea, weakness, and fatigue. b. When there was a change in skin condition on 11/22/18 and the Direct Care Staff (DCS) #3 discovered a small pressure sore on R #1's tailbone. Findings for R #4: C. Record review of R #4's ISP [no date available] revealed, that it was not reviewed and/or updated when a change in condition occurred and home health services were restarted[redacted]19. D. On 02/05/19 at 2:50 pm, during an interview,	A 026		

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A 026	Continued From page 11 the HM confirmed that R #4's ISP was not revised when there was a change of condition 11/22/18.	A 026		
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 (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010]	A 032		

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A 032	Continued From page 12 This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) 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 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.	A 032	7.8.2.32 A (1) - Incident report was not reported to the Licensing Authority as mandated - All suspected cases, known incidences of abuse, incidences of unusual occurrences which has or could threaten the health, safety, or welfare to resident or staff will be reported (and approved by house manager) within 24 hours. - manager to include this in her staff trainings, follow up on all incidents to maintain compliance.	052019

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A 032	Continued From page 13 Based on record review and interview, the facility failed to ensure that incident reports of possible abuse, neglect, exploitation were reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend. This deficient practice has the potential for all 14 (R #s 1-14) residents identified on the census provided by DCS #1 to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority because the facility failed to report incidents of abuse, neglect, and exploitation. The findings are: A. Record review of R #1's resident file revealed no documentation that the following incidents were reported to the Licensing Authority: 1. Record review of R #1's Shift Change Notes dated 11/01/18 to 01/02/2019 revealed that on 12/08/18, R #1 was found with a long-raised bruise of unknown origin on the left lower leg. 2. Record review of [name of facility] Medical Center hospital records dated [redacted]18 revealed R #1 was admitted for an infected stage IV (a serious loss of skin, fat, and bone, tendon, or muscle tissue) pressure ulcer. B. On 02/05/19 at 9:30 am, during an interview with the House Manager, she confirmed that the following incidents were not reported to the Licensing Authority: 1. On 12/08/18, R#1 was found a long-raised bruise of unknown origin on the left lower leg. 2. On [redacted]18, R #1 was admitted to the hospital for an infected stage IV pressure ulcer.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall	A 033		

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A 033	Continued From page 14 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; (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	A 033		

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A 033	Continued From page 15 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 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	A 033		

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A 033	Continued From page 16 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; (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: 7.8.2.33 D (11) (a)	A 033	7.8.2.23 D (11) (a) Re: R#1: PCP was not notified of pressure sore when it was first noticed by DCS. - House manager will read all incident reports and shift charge notes daily to ensure awareness of the happenings in the home & with Residents. - House manager will train DCS on reporting illnesses, injuries and all incidents immediately when noticed. - House manager to notify RN, PCP, and family immediately when noticed, to maintain residents rights & compliance - all wound care must have orders and only qualified personnel such as RN to perform wound care. Physician orders will be monitored	052019

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A 033	Continued From page 17 Based on record review and interview, the facility failed to ensure for 1 (R #1) of 1 (R #1) resident who developed a stage IV pressure sore received wound care/medical attention from qualified healthcare providers. This deficient practice has the potential for residents to be at risk of harm, illness, and death if the: 1. Facility failed to notify the Primary Care Physician (PCP) of the pressure sore. 2. Direct Care Staff (DCS) (not qualified health care providers) were providing wound care/medical treatment for the pressure sore. The findings are: A. Record review of R #1's Shift Change Notes dated 11/01/18 to 01/02/19 revealed that the DCS were treating the resident's pressure sore, and the PCP was not notified of until 12/21/18, as evidenced by: 1. On 11/22/18, DCS #3 noted there was a small pressure sore on her tailbone. 2. On 11/25/18, DCS #2 noted the pressure sore was treated with "cream". 3. On 12/18/18, DCS #3 noted that the bandage was changed on her bottom. 4. On 12/21/18, R #1 was taken to see her Primary Care Provider (PCP) for the pressure sore. B. Record review of R #1's medical records (dated 12/21/18) revealed, the resident was seen by the PCP for a stage IV pressure sore to coccyx (tail bone) with tunneling (channels that extend from a wound into and through tissue or muscle). C. Record review of [name of facility] Medical Center hospital records for R #1 (dated [redacted]18) revealed the resident was admitted for infected stage IV pressure sore.	A 033	weekly by house manager to remain in compliance.	

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A 033	Continued From page 18 D. On 02/05/19 at 10:00 am, during an interview with the House Manager, she confirmed that the following for R #1, the: 1. PCP had not been informed of the pressure sore found by the DCS on 11/22/18 until 12/21/18. 2. DCS (not qualified healthcare providers) were treating the pressure sore with cream.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications.	A 034		

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A 034	Continued From page 19 (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall	A 034		

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A 034	Continued From page 20 be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (1) (4) (9) B (2) Based observation and interview, the facility failed to protect the residents' health and safety by failing to ensure: 1. R #1 had a doctors order to treat her	A 034	7.8.2.34 A(1)(4)(9) B(2) Facility did not have doctors orders to perform wound care. - Manager will assure that doctors order are in residents binder to perform wound care. - House manager will label and store each residents medication separately. All medication including Non-prescription medication will be stored in a locked medication cart. - All discontinued medication or medication of a discharged resident shall be locked in a separate locked storage container for discontinued medication until the pharmacist can destroy it. - Manager to review meds monthly to maintain compliance.	05/20/19

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A 034	Continued From page 21 tailbone pressure sore with over-the-counter (OTC) medications. 2. That medications were labeled with the individual resident's name and stored in separate compartments in the medication cart. 3. The medication stored in the facility First Aid box was not being used on multiple residents. 4. Unused medications are being disposed of properly. This deficient practice has the potential for all 14 residents (R #s 1-14), identified on the census provided by Direct Care Staff (DCS #3) on 02/04/19, to be at risk of being exposed and contracting infectious diseases if: 1. Multiple residents are being given/treated with the same container/tube of medication. 2. Medication was used on more than one resident because it was not not labeled or stored properly. 3. Multiple residents are being given/treated with the same medication that has been contaminated with infectious diseases. 4. Residents share medications and are being treated with non prescribed, inappropriate, or contaminated medications because unused medications are not be disposed of properly. The findings are: A. On 02/05/19 at 10:00 am, during observation and interview with the House Manager (HM) she stated that prior to R #1 being seen by her Primary Care Physician (PCP) on 12/21/19 the facility began treating the residents tailbone pressure sore with OTC Medi Honey 1.5 oz tube of Medihoney-Therahoney (wound care) paste/gel 15 ml-30 ml dosage applied 2x daily. B. On 02/05/19 at 10:30 am, during an observation and interview, the House Manager	A 034	all wound care must have doctors orders and only qualified staff such as RN to perform wound care. - All resident must have their own medication including topical ointments. Residents will not share medication All orders and medication will be monitored by the house manager weekly to maintain compliance.	

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A 034	Continued From page 22 (HM) was asked to provide the medication/Medi Honey that was used on R #1's tailbone pressure sore. The following was observed: 1. The HM opened the facility's First Aid box and presented an almost empty/used 1.5 oz tube of Medihoney-Therahoney (wound care) paste/gel. 2. The HM stated that the medication/Medi Honey observed in the the First Aid box was use to treat resident's wounds. 3. The tube of medication/Medi Honey in the First Aid box was not labeled with R #1's name. 4. The HM stated that Medi Honey stored in the the First Aid box was used to treat "resident's" wounds. 3. The medication/Medi Honey was not stored in a secured separate compartment specifically for R #1's medications. 4. The unused medication left in the tube used to treat R#1's tailbone pressure sore was not disposed of after R#1 was transferred from the facility and admitted to the hospital on [redacted]18. C. On 02/05/19 at 10:45 am, during an interview, the House Manager (HM) confirmed that the used tube of medication (Medi Honey) kept in the facility's First Aid kit should be be disposed of properly by the consulting pharmacist.	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility	A 035		

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A 035	Continued From page 23 without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference	A 035		

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A 035	Continued From page 24 material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse,	A 035		

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	2211	A. BUILDING: _____ B. WING _____	C 02/05/2019

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A 035	Continued From page 25 respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that	A 035		

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A 035	Continued From page 26 assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 A D H Based on observation, record review, and interview the facility failed to ensure for 1 (R #1) of 4 (R #s 1-4) residents whose Physician's Orders were reviewed for compliance that: 1. No medications, including over the counter medication (OTC), was started without physician orders. 2. Only a Licensed Nurse (LN) or Certified Healthcare Professional (CHP) administer any medication. These deficient practices have the potential for all residents to be at risk of physical harm, infection, or illness if: 1. Medications are being used without a physician's order. 2. Non-qualified Direct Care Staff (DCS) are administering medications that only Licensed Nurses or Certified Healthcare Providers's are allowed to administer. The findings are:	A 035	7.8.2.35 A D H - Facility did not have orders to perform wound care. - Facility will have orders in residents binders for all medication and to perform wound care. Staff with a nursing license, LPN, RN will perform wound care with doctors orders LPN/RN to administer medications. - All medication will have an order to start and/or stop medication. - House manager to audit/review binders monthly, make appropriate changes to remain in compliance.	052019

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A 035	Continued From page 27 A. Record review of R #1's Physician's Orders revealed no documentation of a physician's order for Medihoney-Therahoney (wound care) paste/gel 15ml (milliliter) - 30 ml dosage applied 2x [twice] daily. B. On 02/05/19 at 10:00 am, during an interview with the House Manager (HM), she confirmed that: R #1's "wound" was treated with Medihoney-Therahoney (wound care) paste/gel 15ml- 30 ml dosage applied 2x daily by herself and other DCS who are not Licensed Nurses or Certified Health care Professionals. C. On 02/05/19 at 10:30 am, during an observation and interview with the HM, she opened the facility's First Aid kit and picked up a used tube of Medihoney-Therahoney and confirmed that: 1. The used tube of Medihoney-Therahoney from the First Aid kit had been used to treat R #1's "wound". 2. There was no physician's order for the Medihoney-Therahoney. 3. The Medihoney-Therahoney was not administered to R #1 by a Licensed Nurse or Certified Healthcare Professional.	A 035		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC.	A 070		

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A 070	Continued From page 28 B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.70 F 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	A 070	7.8.2.70 F Incidents not being reported when reporting is required. - DCS will report any suspicious incidents to manager and/or Licensing Authority. - All reportable incidents will be reported to Licensing Authority within 24 hours. - All DCS will follow doctors order's and updated ISP. - House manager to monitor and manage all reporting to remain in compliance.	052019

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A 070	Continued From page 29 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 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 that incidents reports of abuse, neglect, exploitation were reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend. This deficient practice has the potential for all 14 (R #s 1-14) residents identified on the census provided by DCS #1 to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority if the facility failed to report incidents of abuse, neglect, and exploitation. The findings are: A. Record review of R #1's resident file revealed no documentation that the following incidents were reported to the Licensing Authority: 1. Record review of R #1's Shift Change Notes dated 11/01/18 to 01/02/2019 revealed that on 12/08/18, R #1 was found with a long-raised bruise of unknown origin on the left lower leg. 2. Record review of [name of facility] Medical Center hospital records dated [redacted]18 revealed R #1 was admitted for an infected stage IV (a serious loss of skin, fat, and bone, tendon, or	A 070		

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A 070	Continued From page 30 muscle tissue) pressure ulcer. B. On 02/05/19 at 9:30 am, during an interview with the House Manager, she confirmed that the following incidents were not reported to the Licensing Authority: 1. On 12/08/18, R#1 was found a long-raised bruise of unknown origin on the left lower leg. 2. On [redacted]'18, R #1 was admitted to the hospital for an infected stage IV pressure ulcer.	A 070		