

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068
---	---

(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 an Initial survey conducted on 10/18/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant	A 016		

Division of Health Improvement

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

TITLE

(X6) DATE

STATE FORM

5509

7FQS11

If continuation sheet 1 of 44

Kelly Holmes

owner/assist admin

4/12/19

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 016	Continued From page 1 training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 016	Continued From page 2 7.8.2.16 B (6) (7) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 016	Continued From page 3 reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 016	Continued From page 4 [7.1.12.8 NMAC - N, 01/01/2006] 7.8.2.16 B (6) (7) Based on record review and interview the facility failed to ensure that the Volunteer Maintenance Worker (VMW) who has direct contact with residents had an: 1. Application submitted and clearance received from the Employee Abuse Registry (EAR) prior to providing volunteer services at the facility. 2. Application and fingerprints submitted to the Criminal Caregiver History Screening Program (CCHSP) within 20-days of beginning to provide maintenance services to the facility. This deficient practice has the potential to affect the safety and welfare of all 8 (R #s 1-8) residents listed on the census provided by the House Manager 10/17/18 if volunteers providing services to the facility have not: 1. Received clearance by the Employee Abuse Registry (EAR), prior to providing services in the facility. 2. Submitted an application and fingerprints within 20-days of providing services to the facility and to the Criminal Caregiver History Screening (CCHSP). The findings are: A. Record request for VMW's (who has direct contact with residents) file revealed, that there was no file or documentation that an: 1. EAR application was submitted and clearance received, prior to providing maintenance services for the facility. 2. Application and fingerprints were submitted to the CCHSP within 20-days after beginning to volunteer at the facility.	A 016	Future VMW who have direct contact with residents will have an application submitted and EAR completed prior to providing services to our facility. The EAR will be completed & reviewed by management and administrator before VMW's are considered. VMW folders will include a background check and fingerprints. Management will renew all VMW applications when submitted to be approved by management/Admin. A list of VMW's will be created & kept in the office. CCHSP will be submitted within 20 days of starting work. A VMW folder will be created and kept in the office and will be review by management or Administrator.	2/20/19

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 016	Continued From page 5	A 016		
	B. On 10/17/18 at 2:13 pm, during an interview with the House Manager, she confirmed that the facility did not complete the EAR/CCHSP background checks as required for the VMW who has direct access to the residents.		VMW's will have the same policy and procedures as staff. P&P Page 5 "Background Checks & Criminal Activity Policy" Pertinent portions quoted: "To ensure the safety and protection of our residents and employees BeeHive Homes will conduct criminal background checks once a conditional offer for a VMW has been extended and or approved.	4/10/19
A 018	7 NMAC 8.2.18 Policies POLICIES: The facility shall have and implement written personnel policies for the following: A. staff, private duty attendant and volunteer qualifications; B. staff, private duty attendant and volunteer conduct; C. staff, private duty attendant and volunteer training policies; D. staff and private duty attendant and volunteer criminal history screening; E. emergency procedures; F. medication administration; G. the retention and maintenance of current and past personnel records; and H. facilities shall maintain records and files that reflect compliance with NM and federal employment rules. [7.8.2.18 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.18 A B C D G H Based on record review and interview, the facility failed to have and implement written personnel policies and procedures (P&P's) for the following:	A 018	Operations Manual P&P Pages 22, 26, 27, 29 and 30. (attached) This summary of those pages address requirements for Volunteer qualifications, conduct, training policies, criminal history screening, retention & maintenance of records and all reflect compliance with NM & federal employment rules pertaining to volunteer workers. A criminal history screening will be implemented. VMW's will be added to our policy and procedures and monitored/reviewed quarterly by management/admin. Quarterly reviews will be documented by House Managers in VMW folder.	4/10/19 4/10/19

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 018	Continued From page 6 1. Volunteer qualifications. 2. Volunteer conduct. 3. Volunteer training policies. 4. Volunteer criminal history screening. 5. The retention and maintenance of current and past personnel records pertaining to volunteer workers. 7. Records and files that reflect compliance with NM and federal employment rules pertaining to volunteer workers. These deficient practices have the potential to affect the safety and welfare of all 8 (R #s 1-8) residents listed on the census, provided by the House Manager on 10/17/18 by not having qualified volunteer staff. The findings are: A. Record review of the facility's undated P&P's manual revealed, that there were no written P&P's for; 1. Volunteer qualifications. 2. Volunteer conduct. 3. Volunteer training policies. 4. Volunteer criminal history screening. 5. The retention and maintenance of current and past personnel records pertaining to volunteer workers. 6. Records and files that reflect compliance with NM and federal employment rules pertaining to volunteer workers. B. On 10/18/18 at 2:13 pm, during an interview with the House Manager, she confirmed that the facility did not have any of the above listed written personnel policies and procedures for volunteer staff.	A 018		
A 020	7 NMAC 8.2.20 Admissions and Discharge	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF BOSQUE FARMS #2

**1935-B BOSQUE FARMS BLVD
BOSQUE FARMS, NM 87068**

(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 020	Continued From page 7 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; (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;	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF BOSQUE FARMS #2

**1935-B BOSQUE FARMS BLVD
BOSQUE FARMS, NM 87068**

(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 020	Continued From page 8 (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 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;	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF BOSQUE FARMS #2

**1935-B BOSQUE FARMS BLVD
BOSQUE FARMS, NM 87068**

(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 020	Continued From page 9 (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 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	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 020	Continued From page 10 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] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) (12) (a-b) (13) refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF BOSQUE FARMS #2

**1935-B BOSQUE FARMS BLVD
BOSQUE FARMS, NM 87068**

(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 020	Continued From page 11 POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them. C. For the purposes of this section,	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 020	Continued From page 12 "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately. Based on record review and interview, the facility failed to ensure for 1 (R #3) of 3 (R #s 1-3) residents, whose admission agreements were reviewed for accuracy and completeness, were missing the following required information: 1. Refund policy for death, transfer, voluntary or involuntary discharge. 2. The admission agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: a. There shall be a fifteen (15) day written notice of termination given. b. Resident fails to pay. 3. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. These deficient practices have the potential for residents/legal representatives to be at risk of being: 1. Unaware of any refund that may be due to the resident or their estate. 2. Discharged before an appropriate placement was found for failure to pay. 3. Charged for new/changed care services without the appropriate 30-day notice. The findings are: A. Record review of R #3's Admission Agreement (dated 07/05/18) revealed, it was missing the following required information: 1. A refund provision in case of death that	A 020	Admissions and Discharge Resident files will be updated with a new admission /discharge agreement. A 15 day written notice to the resident or his agent/guardian if appropriate placement has been found, unless the resident requests termination. The facility will provide a 30 day written notice to the resident or his agent/guardian regarding any changes in cost or material services provided. The manager/Admin will do monthly chart review and stay in compliance with state. An update for our Resident Refund Policy was submitted in our Admissions Packet on 3/27/19. It states: Residents that are admitted during the month will be charged a pro-rated amount for the first month. Should a death occur, room charges will be prorated up to seven days after the death of the resident or the date that all items have been removed by the family. The facility has a NO REFUND policy for discharges that occur, except in the case of death, including termination, discharge, transfer or eviction. Storage of Resident Belongings following Death... "4/10/2019 If a resident's belongings are not removed within 1 week of the death of the resident, the facility will charge no more than 10 percent of the daily rate for us to 45 days for the storage of the residents belongings. The facility reserves the right to remove the residents belongings from the room after 7 days of the passing of the resident. If the residents personal belongings have not been removed within 46 days of the residents death the facility reserves th right to dispose of the items. R#3 was transferred from another facility and his application wasn't updated. The old application has been destroyed. The new application has the correct information and will be used from this point on. Transfers from other facilities will have a new application to complete when they are admitted to our facility.	4/10/2019

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 020	Continued From page 13 complied with state statutes for a prorated refund. 2. May be terminated if an appropriate placement is found for the resident. 3. A 15-day written notice for termination for non-payment of rent. 4. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. B. On 10/17/18 at 11:30 am, during an interview with the House Manager, she confirmed that R #3's Admission Agreement was missing the following required information: 1. A refund provision in case of death that complied with state statutes for a prorated refund. 2. May be terminated if an appropriate placement is found for the resident. 3. A 15-day written notice for termination for non-payment of rent. 4. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services.	A 020		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans;	A 022		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF BOSQUE FARMS #2

**1935-B BOSQUE FARMS BLVD
BOSQUE FARMS, NM 87068**

(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 022	Continued From page 14 (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies: (a) an emergency that affects just the facility; and (b) a region/area wide emergency; (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC);	A 022		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 022	Continued From page 15 (12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and (13) vaccination records for pets in the facility. B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances.	A 022		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068
---	---

(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 022	Continued From page 16 D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies;	A 022		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 022	Continued From page 17 (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident 's personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (10) (a-b) Based on record review and interview the facility failed to ensure that they had written policies for: 1. Emergency evacuation plan for a facility disasters. 2. Emergency evacuation plan for community wide disaster. This deficient practice has the potential for all 8 (R #s 1-8) residents listed on the census, provided by the Administrator on 12/17/18, to be at risk of harm, injury, and/or death if: 1. A facility disaster occurred and the residents were unable to be safely evacuated	A 022	4/10/2019 Facility Reports, Records, Rules, Policies The facility Emergency Evacuation Plans and community wide disaster plans have been posted in the med room and in the entry for easy access. Training by house managers will be provided to all staff once a month. Fire drills are also conducted monthly. The local fire chief has agreed to assist us in transporting residents, if needed, to a safe place in the event of an emergency evacuation. Administrator will check quarterly to make sure trainings are conducted and record in our trainings binder. During a facility disaster residents will be transferred to the other facility on site and or to the greenhouse on site. A monthly list of residents medications will be kept in a binder in the medication room along with their pharmacies for easy access. Management has access to all of the residents medication lists through our computerized medication program, and can access it with any computer.	4/10/19 8/24/18

Division of Health Improvement

STATE FORM

6899

7FQS11

If continuation sheet 18 of 44

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF BOSQUE FARMS #2

**1935-B BOSQUE FARMS BLVD
BOSQUE FARMS, NM 87068**

(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 022	Continued From page 18 from the facility. 2. A community wide disaster occurred and the residents were unable to be safely evacuated from the community. The findings are: A. Record request for the emergency evacuation plan for a facility disaster revealed, that the facility had no documentation that there was a facility disaster plan in place. B. Record request for the emergency evacuation plan for community wide disasters revealed, that the facility had no documentation that there was a facility plan in place for a community wide disaster. C. On 10/18/18 at 11:50 am, during an interview with the House Manager, she confirmed that the facility does not have a written emergency evacuation plan for a facility or a community wide disaster.	A 022		
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	A 026		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 026	Continued From page 19 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; (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 (2) Based on record review and interview, the facility failed to ensure for 3 (R #s 1-3) of 3 (R #s 1-3) residents whose Individual Service Plans (ISP's) were reviewed for compliance, were signed as reviewed by a nurse for accuracy. This deficient practice has the potential for residents to not	A 026	The house nurse will review all ISP's when created or when there is a change. All ISP's will be reviewed quarterly by our Nurse/House Manager. A list will be generated and kept in the office for review.	3/7/19

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 026	Continued From page 20 receive the appropriate care/assistance needed if the ISP has not been reviewed by a nurse for accuracy. The findings are: A. Record review of R #s 1-3 ISP's revealed, they were not signed as reviewed by a nurse: 1. R #1 completed 10/16/18 2. R #2 completed 09/04/18 3. R #3 completed 09/11/18 B. On 10/17/18 at 11:50 am, during an interview with the House Manager, she confirmed R #s 1-3 ISP's were not signed as reviewed by a nurse.	A 026		
A 031	7 NMAC 8.2.31 Handling of Emergencies HANDLING OF EMERGENCIES: A. Upon admission, each resident or surrogate decision maker shall designate a primary care practitioner (PCP) to be called in case of a medical necessity. Each resident or representative shall also designate a concerned person to be called in case of an emergency. The facility shall establish a policy to secure medical assistance if the resident's own physician is not available. In the event of an illness or an injury to the resident, the PCP or a physician extender shall be notified by the facility. B. The facility shall have a first aid kit that contains at a minimum, gauze, adhesive tape, antiseptic ointment and bandages for emergencies. The first aid kit shall be kept in a designated, easily accessible place within the facility. C. An easily accessible and functional telephone shall be available in each facility for summoning help in case of an emergency. A pay telephone does not fulfill this requirement. D. A list of emergency numbers including: fire	A 031	Handling of Emergencies Emergency numbers (including fire department, police department, ambulance, Poison control and 911) are posted in the med room and in the entry, by the front door, for easy access for residents. House Managers will make sure the emergency numbers are visible at all times where residents, family members and visitors can see them and they will check annually to ensure that the numbers are still posted.	10/19/18

Type text here

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

BEEHIVE HOMES OF BOSQUE FARMS #2

STREET ADDRESS, CITY, STATE, ZIP CODE

**1935-B BOSQUE FARMS BLVD
BOSQUE FARMS, NM 87068**

(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 031	Continued From page 21 department, police department, ambulance services and poison control shall be posted near each public telephone in the facility. [7.8.2.31 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.31 D Based on observation and interview, the facility failed to ensure that a list of emergency phone numbers (fire, police, ambulance, poison control, etc) was posted in a conspicuous place and accessible to residents/family's/visitors. This deficient practice has the potential for all 8 (R #s 1-8) residents identified on the census provided by the House Manager on 10/17/18, to be at risk of delayed response from emergency services and to potentially not receive needed first aid/medical treatment. The findings are: A. On 10/18/18 at 11:46 am, during an observation no emergency numbers (fire, police, ambulance, poison control, etc) were observed to be posted in the residents' phone room or on the outside of the front desk where residents/families/visitors have access to the phone. B. On 10/18/18 at 11:46 am, during an interview with House Manager, she confirmed the observation that there were no emergency numbers (fire, police, ambulance, poison control, etc) posted in the residents' phone room or on the outside of the desk where residents/families/visitors have access to the	A 031		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF BOSQUE FARMS #2

**1935-B BOSQUE FARMS BLVD
BOSQUE FARMS, NM 87068**

(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 031	Continued From page 22 phone.	A 031		
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; (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	A 033		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 033	Continued From page 23 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 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	A 033	Type text here	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 033	Continued From page 24 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; (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]	A 033		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 033	Continued From page 25 This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (4) Based on observation and interview, the facility failed to ensure that all doors could be readily opened from the inside when locked. This deficient practice has the potential for all 8 (R #s 1-8) residents listed on the census provided by House Manager on 10/17/18, to be at risk of injury or harm if approved exit doors are locked and they can't open them in the event of a fire, loss of power, or an emergency that requires evacuation. The findings are: A. On 10/18/18 at 11:50 am, during an observation of the door exiting to the North of the building, it was observed that the door had a dead bolt that was locked along with a door handle that would not release the deadbolt. B. On 10/18/18 at 11:52 am, during an observation of the door exiting to the South of the building, it was observed that the door had a dead bolt that was locked along with a handle that would not release the deadbolt. C. On 10/18/18 at 11:54 pm am during an observation of the door exiting to the front of the building, it was observed that the door had a dead bolt that was locked along with a handle that would not release the deadbolt. D. On 10/18/18 at 11:57 am, during an interview with the House Manager, she confirmed the observations that the doors exiting to the front of the facility and North and South to the back of the facility had a dead bolt that was locked along with	A 033	Resident Rights The doors do not release upon activation of the fire alarm, sprinkler system, and/or a power failure. Corrective action will be to ensure that all existing residents and all future residents are able to unlock and open the doors. Manager or assistant manager will check the residents upon admission and also quarterly during their stay and we will log results in their binder. Actions taken: Deadbolts were removed and the front door has a deadbolt only (no lock on door knob) All exit doors only have one lock each. All residents can physically unlock the exit doors at this time.	4/10/19

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 033	Continued From page 26 a handle that would not release the deadbolt.	A 033		
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 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.	A 035		

Division of Health Improvement
STATE FORM

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 035	Continued From page 28 (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, 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	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 035	Continued From page 29 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 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 G (4) (5) Based on observation, record review and interview the facility failed to ensure for 3 (R #s 1-3) of 3 (R #s 1-3) residents whose records were reviewed and who were observed during the medication (med) pass that: 1. Only a licensed nurse or certified healthcare professional conduct an invasive procedure and administer medications. 2. The Medication Administration Record (MAR) was accurate and contained all the	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 035	Continued From page 30 required information. These deficient practice has the potential for residents to be at risk of harm if: 1. Done incorrectly causing excessive bleeding and/or infection if exposed to bacteria/germs. 2. The information on the MAR is not complete, accurate, and includes all required information then medication errors could occur and result in residents being harmed or require medical treatment. The findings are: Findings for Medication Pass A. On 10/18/18 at 11:12 am, during an observation of the medication pass Direct Care Staff (DCS) #4 was observed pricking R #3's finger for her blood sugar check. B. On 10/18/18 at 11:14 am, during observation of medication pass DCS #4 was observed injecting medication (insulin) with a syringe into R #3's abdomen. C. On 10/18/18 at 11:20 am, during an interview with DCS #4, she confirmed pricking R #3's finger for a blood sugar check and injecting medication (insulin) with at syringe into the resident's abdomen. Findings for MAR D. Record review of R #1's MAR 10/01/18 to 10/17/18 revealed, the following missing information: 1. Diagnosis for the following medications: a. Fluticasone - Flonase (allergies).	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	---	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF BOSQUE FARMS #2

**1935-B BOSQUE FARMS BLVD
BOSQUE FARMS, NM 87068**

(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 035	Continued From page 31 b. Iron - Ferrous Gluconate (supplement). c. Melatonin - Zolsoma (insomnia). d. Synthroid - Levothyroxine (thyroid). 2. Diagnosis and brand/generic for the following medications: a. Calcium - Calphron (supplement). b. Cimetidine - Tagament (heartburn). c. Lisinopril - Zestoretic (blood pressure) d. Multivitamin - Centrum (supplement). e. Surtraline - Zoloft (depression). f. Tylenol - Acetaminophen (pain). g. Vitamin B - Complex B (supplement). h. Vitamin D - Citracal (supplement). B. Record review of R #2's MAR 10/01/18 to 10/17/18 revealed, the following missing information: 1. Diagnosis for the following medications: a. B-12 shot - Cyanocobalamin (supplement). b. Complete Omega - Lovaxa (supplement). c. Cyanocobalamin - Vitamin B (supplement). d. Furosemide - Lasix (edema). 2. Brand/generic for the medication Acetaminophen - Tylenol (pain). 3. Diagnosis and brand/generic for the following medications: a. Black Seed - New Chapter (supplement). b. Ferrous Sulfate - Feosol (supplement). c. Fineasteride - Proscar (prostate). d. Gabapentin - Neurontin (pain). e. Lysine - Abreva (cold sores). f. Magnesium Oxide - Mag-Ox (supplement). g. Metamucil - Benefiber (supplements). h. Omeprazole - Prilosec (heartburn).	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 035	Continued From page 32 i. Sotalol - Betapace (heart rhythms). j. Ultimate Flora - Lactobac (digestion). k. Warfarin - Coumadin (blood thinner). C. Record review of R #3's MAR 10/01/18 to 10/17/18 revealed, the following missing information: 1. Brand/generic for the following medications: a. Lactulose - Constulose (constipation). b. Melatonin - Zolsoma (insomnia). c. Mucinex - Guaifenesin (secretion). d. Senna - Senokot (constipation). e. Tylenol - Acetaminophen (pain). 2. Brand/generic and diagnosis for the following medication: a. Acyclovir - Zpivirax (cold sores). b. Aspirin - Bayer (fever/pain). c. Ipratropium Albuterol - Atrovent (asthma). d. Mirtazapine - Remeron (depression). e. Novolog - Lispro (diabetes). f. Polyethylene Glycol - Miralax (constipation). g. Vitamin D3 - Drisdol (supplement). D. On 10/18/18 at 11:50 am, during an interview with the House Manager, she confirmed the above listed findings for R #s 1-3's 10/01/18 to 10/17/18 MAR's and R #3's finger prick and insulin injection.	A 035		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry	A 037		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 037	Continued From page 33 and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet.	A 037		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 037	Continued From page 34 B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (10) Based on observation and interview the facility failed to ensure that laundry and cleaning supplies were kept in a secured room, closet, or cabinet. This deficient practice has the potential for all 8 (R #s 1-8) residents identified on the census provided by the House Manger on 10/17/18, to be at risk of harm or injury if they were to ingest or spill laundry or cleaning supplies on their face or body. The findings are: A. On 10/17/18 at 2:45 pm, during an observation of the unlocked cabinet under the kitchen sink, the following cleaning supplies were observed to be accessible to residents: 1. (2) 32 oz (ounce) bottles of automatic dishwasher spot remover. 2. (1) 32 oz bottle of window cleaner. 3. (1) gallon of liquid sanitizer. 4. (1) 135 oz bottle of dishwashing soap. 5. (1) 135 count container of automatic dishwasher cleaning pods. 6. (1) 28 oz can of abrasive scrubbing powder. B. On 10/17/18 at 2:52 pm, during an interview with the House Manager, she confirmed that the above listed laundry and cleaning supplies were in the unlocked cabinet under the kitchen sink	A 037	LAUNDRY SERVICES The cabinet under the sink in the kitchen has a lock on it. The House manager will check doors weekly and make sure they are locked and not accessible to residents. Kitchen cooks will also be trained in keeping cabinet under the kitchen sink locked at all times when not in use.	10/18/18

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 037	Continued From page 35 and accessible to residents.	A 037		
A 049	7 NMAC 8.2.49 Doors DOORS: A. No door in any means of egress shall be locked against egress when the building is occupied. (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for	A 049		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2			STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 049	Continued From page 36 every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities. E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside. F. All doors shall readily open from the inside. G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms. [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.49 A (1) Based on observation and interview, the facility failed to ensure that all doors could be readily opened from the inside when locked. This deficient practice has the potential for all 8 (R #s 1-8) residents listed on the census provided by House Manager on 10/17/18, to be at risk of injury or harm if approved exit doors are locked and they can't open them in the event of a fire, loss of power, or an emergency that requires evacuation. The findings are: A. On 10/18/18 at 11:50 am, during an observation of the door exiting to the North of the building, it was observed that the door had a dead bolt that was locked along with a door handle that would not release the deadbolt. B. On 10/18/18 at 11:52 am, during an observation of the door exiting to the South of the building, it was observed that the door had a dead bolt that was locked along with a handle that would not release the deadbolt. C. On 10/18/18 at 11:54 pm am during an	A 049	DOORS The doors do not relase upon activation of the fire alarm, sprinkler system, and/or a power failure. Corrective action will be to ensure that all residents are able to unlock and open exit doors. At this time all residents in House #2 are able to open all doors that have a lock or dead bolt on them. We have removed the deadbolts from the North & South exit doors on the building. All exit doors only have one lock and all residents are able to unlock the doors. Manager or assistant manager will check the residents during quarterly evaluations and we will log results in their binders.	4/10/19 4/10/19 4/10/19	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 049	Continued From page 37 observation of the door exiting to the front of the building, it was observed that the door had a dead bolt that was locked along with a handle that would not release the deadbolt. D. On 10/18/18 at 11:57 am, during an interview with the House Manager, she confirmed the observations that the doors exiting to the front of the facility and North and South to the back of the facility had a dead bolt that was locked along with a handle that would not release the deadbolt.	A 049		
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. 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	A 070	Future VMW who have direct contact with residents will have an application submitted and EAR completed prior to providing services to our facility. The EAR will be completed & reviewed by management and administrator before VMW's are considered. VMW folders will include a background check and fingerprints. Management will renew all VMW applications when submitted to be approved by management/Admin. A list of VMW's will be created & kept in the office. CCHSP will be submmittdd within 20 days of starting work. A VMW folder will be created and kept in the office and will be reviewed by management or Administrator.	2/20/19

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF BOSQUE FARMS #2

**1935-B BOSQUE FARMS BLVD
BOSQUE FARMS, NM 87068**

(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 070	Continued From page 38 by: 8 (R #s 1-8) (#8 is a respite resident) 7.8.2.70 D E Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information	A 070		

Division of Health Improvement

STATE FORM

6899

7FQS11

If continuation sheet 39 of 44

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 070	Continued From page 39 concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any	A 070		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF BOSQUE FARMS #2

**1935-B BOSQUE FARMS BLVD
BOSQUE FARMS, NM 87068**

(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 070	Continued From page 20 contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: ... D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four (\$74) dollars. Of which, twenty-four (\$24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven (\$7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department.	A 070		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068
---	---

(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 070	Continued From page 41 ... E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees	A 070		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 070	Continued From page 42 and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. 7.8.2.70 D E Based on record review and interview the facility failed to ensure that the Volunteer Maintenance Worker (VMW) who has direct contact with residents had an: 1. Application submitted and clearance received from the Employee Abuse Registry (EAR) prior to providing volunteer services at the facility. 2. Application and fingerprints submitted to the Criminal Caregiver History Screening Program (CCHSP) within 20-days of beginning to provide maintenance services to the facility. This deficient practice has the potential to affect the safety and welfare of all 8 (R #s 1-8) residents listed on the census provided by the House Manager 10/17/18 if volunteers providing services	A 070		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2018
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BOSQUE FARMS #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068		
(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 070	Continued From page 43 to the facility have not: 1. Received clearance by the Employee Abuse Registry (EAR), prior to providing services in the facility. 2. Submitted an application and fingerprints within 20-days of providing services to the facility and to the Criminal Caregiver History Screening (CCHSP). The findings are: A. Record request for VMW's (who has direct contact with residents) file revealed, that there was no file or documentation that an: 1. EAR application was submitted and clearance received, prior to providing maintenance services for the facility. 2. Application and fingerprints were submitted to the CCHSP within 20-days after beginning to volunteer at the facility. B. On 10/17/18 at 2:13 pm, during an interview with the House Manager, she confirmed that the facility did not complete the EAR/CCHSP background checks as required for the VMW who has direct access to the residents.	A 070		