STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4037	A. BUILDING: _____ B. WING _____	C 07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF WHITE ROCK	110 LONGVIEW DRIVE WHITE ROCK, NM 87544

(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	A 000		

The following deficiencies were cited during a Complaint survey completed on [redacted]/23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities for Adults.

Complaint [redacted] was investigated with no deficiencies cited.
Complaint [redacted] was investigated with deficiencies cited.

Census: 12

DEFINITIONS/ACRONYMS/ABBREVIATIONS:

<: less than
ac: before meals
ALF: Assisted Living Facility
AREDS: Age-related eye disease study
asap: as soon as possible
BID: Twice daily
BM: Bowel movement
BPH: Benign prostatic hyperplasia
cap: capsule
CBG: Capillary blood glucose
CVA: Cerebrovascular accident/stroke
DCS: Direct Care Staff
DON: Director of Nursing
Dx: Diagnosis
EMS: Emergency Medical Service
ER: Emergency Room
g: gram
Glucagon Emergency Kit: a medication used to treat low blood sugar in diabetics
HCl: Hydrochloric acid
HS: bedtime (hours of sleep)
ICaps: Multivitamin with minerals
IM: intramuscular
LA: Licensing Authority
LPN: Licensed Practical Nurse

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A 000	Continued From page 1 mcg: microgram mg: milligram ml: milliliter neuropathy: conditions that affect the peripheral nerves, causing symptoms such as numbness, tingling, or pain or weakness/often associated with diabetes. o.d.: once per day OTC: over the counter pc: after meals PCP: primary care physician PO: by mouth POA: Power of Attorney PRN: Pro re nata (as needed) q4h: every 4 hours q6h: every 6 hours q8h: every 8 hours q12h: every 12 hours qam: every morning QD: every day R: Resident RN: Registered Nurse recon soln.:reconstituted (dry substance to fluid form) solution SQ: subcutaneous sym.: symptom tab: tablet UTI: Urinary Tract Infection w/: with w/o: without	A 000		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy.	A 034		

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A 034	Continued From page 2 A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained	A 034		

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A 034	Continued From page 3 separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation.	A 034		

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A 034	Continued From page 4 (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A Based on record review and interview, the facility failed to ensure for [redacted] residents whose medications were reviewed for compliance that their medications were available at the facility. This deficient practice could likely result in the residents to be at risk of harm, injury, and death if prescribed medications are not available to be taken as prescribed. The findings are: A. Record review of Complaint Intake Report [redacted] dated [redacted]/23, stated that R #2 "...was not given medications and almost died. Facility staff said they were out of medications for several days, but did not tell family that. If family did not call 911, ER doctor said resident would be dead. [redacted] glucose level was so bad [redacted] was incoherent." (Intake record does not state glucose level).	A 034	Drug Permit is posted in the home in the staff office. The Operations Manager will be responsible for keeping that posting up Beehive homes of White Rock will not admit any resident into the home without having medications in hand before/ day of admission. Staff retrained by Operations Director. Administrator will monitor all future admissions into Beehive	8/3/23

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A 034	Continued From page 5 B. Record review of facility's Record of Medication Received log dated [redacted]/23 through [redacted]/23, revealed: 1. [redacted] was not delivered to the facility until [redacted]/23. 2. The facility did not receive the following medications ordered by R #2's physician: a. [redacted] b. [redacted]. c. [redacted]. C. On [redacted]/23 at 2:53 pm, during an interview, the Administrator confirmed: 1. R #2 was admitted to the facility on [redacted]/23. 2. R #2's previous residence (nursing home) Assistant Discharge Planner had been stating (daily, since admission) to the Administrator that the [redacted] medication had been ordered by them, and that they were waiting on the pharmacy. 3. On [redacted]/23, when the Administrator inquired with the nursing home's DON regarding the status of the [redacted] medication, the nursing home's DON told her it had never been ordered. 4. The [redacted] medication was ordered on [redacted]/23 and it was delivered to the facility on [redacted]/23. 5. The [redacted] was given to R #2 on [redacted]/23. [redacted] missed it for at least eleven (11) days. D. Record review of R #2's Medication Administration Records (MAR) from [redacted]/23 through [redacted]/23, revealed the following prescribed medications were not available to R #2 for the following dates: 1. [redacted]/23 [redacted]/23, [redacted]	A 034	Beehive staff will order medications refills 7 days before medication is out. Staff was retrained by Operations Director. Operations Manager will be monitoring and ordering medications	8/3/23

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A 034	Continued From page 6 was missed for two (2) days. 2. [redacted]/23 [redacted]/23, PRN: [redacted]. was unavailable for eighteen (18) days. 3. [redacted]/23-[redacted]/23, [redacted] BID was unavailable for ten (10) days. 4. [redacted]/23-[redacted]/23, [redacted](diagnosis unknown) [redacted] unavailable for two (2) days. 5. [redacted]/23-[redacted]/23 and on [redacted]/23, [redacted] was unavailable for 3 days. 6. [redacted]/23 [redacted]/23, [redacted] was unavailable for eleven (11) days. 7. [redacted]/23 [redacted]/23, [redacted] was unavailable for three (3) days. E. On [redacted]/23 at 4:22 pm, during an interview with the Operations Director and the Administrator, they confirmed R #2's medications not being available at the facility. F. On [redacted]/23 at 4:25 pm, during an interview with the Managing Director of R #2's pharmacy, the Pharmacist confirmed the following risks to R #2 if the following medications were missed: 1. [redacted] a. Within 1-2 days of missing this medication, it can cause [redacted]. b. Can [redacted]. c. This will not lead to [redacted]. 2. PRN: [redacted]. [redacted] Needed if [redacted]. Risks if medication is unavailable: All ALF's and nursing homes with [redacted] residents must have this on hand because it is lifesaving. 3. [redacted]	A 034		

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A 034	Continued From page 7 medication for 2-days are low-risk and it would take many months of missing this to cause additional risk to health. 4. [redacted] Risks for missed medication: a. Reduces [redacted] or [redacted] b. Missing for even one (1) day could cause problems c. If missed, it should be taken immediately, and the resident's doctor should be alerted ASAP because the doctor may need to intervene until the medication is absorbed in the body and the resident is back to normal 5. [redacted] Risks for missing: It is not a major risk if missed for a few days because it is a maintenance medication for an [redacted]. 6. [redacted] Medication was missed for eleven (11) days; following are risks and concerns: a. Pharmacy's notes stated that on [redacted]/23, the facility was notified the insurance did not cover this specific brand. b. Missing this medication for 11 days would adversely effect [redacted] c. Missing this medication for 11 days would have definitely contributed to [redacted] d. The facility should have discussed that the resident had missed the medication for 11 days with the resident's physician. G. On [redacted]/23 at 2:29 pm, during an interview, Operations Manager stated: 1. R #2's physician ordered the [redacted] 2. The facility did not order the kit because they	A 034		

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A 034	Continued From page 8 are not allowed to administer medications. 3. R #2 can [redacted] on his own.	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility 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	A 035	Beehive staff was retrained by Operations Manager on medications and diagnosis. Along with Medication protocol and documentation. Beehive staff was retrained by Operations Manager regarding adding both brand and generic names to medications in the MARS. Beehive was retrained by Operations Manager regarding medication and diagnosis. Operations Manager will be training staff moving forward Beehive was retrained on Protocols regarding medications. Operations Manager will be responsible for future trainings	8/3/23

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A 035	Continued From page 9 primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug;	A 035		

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A 035	Continued From page 10 (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, 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	A 035		

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A 035	Continued From page 11 packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that 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 G (4, 5, 19) Based on record review and interview, the facility failed to ensure for [redacted] residents whose Medication Administration Records (MAR) were reviewed for compliance were accurate, complete, and included all the following required information: 1. Physician's orders for all medications listed on the MAR. 2. The diagnosis or reason for the medication	A 035		

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A 035	Continued From page 12 3. Medications were missed and the reason the medication was missed. These deficient practices could likely negatively affect the health, safety, and welfare of the residents, if medication errors occur, because the information on the MAR is not accurate, complete, and includes all required information. The findings are: Physician's orders: A. Record review or R #2's resident file revealed, the record did not contain any documentation of a Physician's order for [redacted] but it was listed on R #2's [redacted] /23 through [redacted] /23 MARs. B. Record review of R #2's resident file revealed (including physician's orders and [redacted] 2023 through [redacted] 2023 MARs), the following medications were ordered by the resident's physician, but were not listed on the resident's [redacted] /23 through [redacted] /23 MARs: 1. PRN: [redacted] 2, no stop date. 2. [redacted] ordered on [redacted] /23, no stop date. C. On [redacted] /23 at 4:22 pm, during an interview, the Operations Manager confirmed: 1. R #2's Physician's order for [redacted] was unavailable. 2. PRN: [redacted] were ordered by R #2's Physician, but were not listed on the MAR.	A 035		

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A 035	Continued From page 13 Findings related to brand and generic names: D. Record review of R #2's MARs dated [redacted]/23 through [redacted]/23, revealed the MARs did not include both brand and generic names for the following medications: 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] 5. [redacted] 6. [redacted] 7. [redacted] 8. [redacted] 9. [redacted] 10. [redacted] 11. [redacted] 12. [redacted] 13. [redacted] 14. [redacted] 15. [redacted] 16. [redacted] 17. [redacted] E. On [redacted]23 at 4:22 pm, during an interview, the Operations Manager confirmed that R #2's MARs dated [redacted]/23 through [redacted]/23, did not include both brand and generic names for the medications listed above. Findings related to diagnosis or reason for medication: F. Record review of R #2's MARs dated [redacted]/23 through [redacted]/23, revealed the MAR did not include the diagnosis or reason for the following medications:	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4037	A. BUILDING: _____ B. WING _____	C 07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF WHITE ROCK	110 LONGVIEW DRIVE WHITE ROCK, NM 87544

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A 035	Continued From page 14	A 035		

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]
6. [redacted]
7. [redacted]
8. [redacted]
9. [redacted]
10. [redacted]
11. [redacted]
12. [redacted]
13. [redacted].
14. [redacted]
15. [redacted]
16. [redacted]

G. On [redacted]/23 at 4:22 pm, during an interview, the Operations Manager confirmed R #2's [redacted]/23 through [redacted]/23 MARs did not include the diagnoses or reason for the medications listed on the MAR.

H. On [redacted]/23 at 2:53 pm, during an interview, the Administrator confirmed the dosing directives for the medications listed on R #2's MAR were unclear and they could cause a medication error to occur.

Findings related to missed medication:

I. Record review of R #2's MAR dated [redacted]/23 through [redacted]/23, revealed the exception coding footnotes for the missed doses of [redacted], take [redacted] were inconsistent and contradictory on the following sampled dates and times:
1. [redacted]/23:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4037	A. BUILDING: _____ B. WING _____	C 07/31/2023

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A 035	Continued From page 15 a. 8:00 am dose: Exception #20 listed the following three reasons why the medication was missed or given "Other-Not available-Administered as prescribed. b. 12:00 pm dose: Exception #26 listed the following three reasons why the medication was missed or given "Medication unavailable-Not available-Administered as prescribed. c. 5:00 pm dose: Exception #25 listed the following three reasons why the medication was missed or given " Other-Not available-Administered as prescribed. 2. [redacted]/23: a. 8:00 am dose: Exception #22 listed the following three reasons why the medication was missed or given "Medication unavailable-Medication unavailable-Administered as prescribed. b. 5:00 pm dose: Exception #29 listed the following three reasons why the medication was missed or given "Medication unavailable-Medication unavailable-Administered as prescribed. 3. [redacted]/23: a. 8:00 am dose: Exception #24 listed the following three reasons why the medication was missed or given "Medication unavailable-Med Dc (discontinued)-Administered as prescribed. b. 12:00 pm dose: Exception #28 listed the following three reasons why the medication was missed or given "Medication unavailable-No med (medication)-Administered as prescribed. J. On [redacted]/23 at 11:30 am, during an interview, the Administrator confirmed the exception coding footnotes for [redacted] on R #2's MAR were contradictory and confusing and could cause a medication error to occur.	A 035		