Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4033	A. BUILDING: ______ B. WING ______	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF RATON	1465 TURNESA ST RATON, NM 87740

(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 10/04/18 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 [signature] TITLE Administrator (X6) DATE 1/3/19

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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		

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A 016	Continued From page 2 7.8.2.16 A B (3) 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	Violation 7.8.2.16 A, B (3) The facility will ensure that all CURRENT and FUTURE employees have been processed and cleared through the EMPLOYEE ABUSE REGISTRY. A) Requirement to inquire of registry prior to employment B) Prohibited employment C) Applicant's identifying information required D) Documentation of inquiry to registry E) Documentation for other staff F) Consequences of noncompliance All employee files were reviewed to ensure that employees have been processed and cleared through the EMPLOYEE ABUSE REGISTRTY. All required documentation has been placed in employee files. Ongoing compliance will be conducted and monitored by house manager and administrator. Management will use the company approved "New Hire Checklist" to monitor ongoing compliance. This Violation will be corrected no later than 2-4-19.	

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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		

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A 016	Continued From page 4 [7.1.12.8 NMAC - N, 01/01/2006] Based on record review and interview the facility failed to ensure that: 1. A full time Administrator was available to supervise the facility. 2. Direct Care Staff (DCS) have been cleared by the Employee Abuse Registry (EAR) prior-to-hire. This deficient practice has the potential to negatively affect the safety and welfare of all 12 (R #s 1-12) of 12 (R #s 1-12) residents listed on the census provided by the house Manager on 10/01/18 if: 1. There is no full time Administrator to supervise the facility and to oversee the care being provided to the residents. 2. They are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents or have a felony conviction. The findings are: Findings related to the Administrator A. Record review of the facility license revealed that the person named as the Administrator was not available at the facility full-time and does not work/live within a 40 mile radius. The facility license only indicates the name of the administrator not where he/she lives or how many hours he/she works, what document was reviewed to get this information? Please update B. On 10/01/18 at 2:27 pm, during an interview with the House Manager, she confirmed that the Administrator listed on the facility license does not live/work in within a 40 mile radius of the facility, and only visits the facility occasionally.	A 016	7.1.12.8 NMAC The facility will provide a full-time Administrator that will not administer over multiple facilities that are without a 40 mile radius. The Administrator will ensure: 1) The onsite supervision of the facility. 2) That Direct Care Staff have been cleared by the Employee Abuse Registry. A) Administrator will be available B) at the facility full-time and within 40 mile radius. This Violation will be corrected no later than 2-4-19.	

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A 016	Continued From page 5 Findings related to EARs C. Record review of DCS #1's employee file revealed, a hire date of 05/31/18 and the EAR was not submitted until 06/06/18 and the Final Registry Summary is missing the EAR clearance page. D. Record review of DCS #2's employee file revealed, a hire date of 01/02/18 and the EAR was not submitted until 01/17/18. E. On 10/02/18 at 11:24 am, during an interview with the House Manager, she confirmed for DCS #s 1 & 2 that the EARs were not submitted and clearances received prior to hire. In addition, the House Manager confirmed that DCS #1's Final Registry Summary is missing the EAR clearance page.	A 016		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment;	A 020		

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A 020	Continued From page 6 (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; (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	A 020		

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A 020	Continued From page 7 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 physicalor chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis thatrequires isolation techniques; (10) residents that require the use of a Hoyerlift; and (11) ostomy (unless resident is able toprovide 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	A 020		

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A 020	Continued From page 8 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 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.	A 020		

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A 020	Continued From page 9 (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 D (1) Based on record review and interview the facility failed to ensure for 1 (R #4) of 1 (R #4) resident identified on the resident census as receiving hospice services, that the Individual Service Plan (ISP) had evidence of care coordination with the hospice agency. This deficient practice has the potential for the residents who have elected to receive hospice services to be at risk of harm if the Direct Care Staff (DCS) do not know what services they are to provide and what services the hospice agency will provide. The findings are: A. Record review of R #4's ISP (dated07/17/18) revealed, it did not include coordination of care between the facility and the hospice agency. B. On 10/02/18 at 2:20 pm, during an interview with the House Manager, she confirmed that R #4's ISP did not include coordination of care between the facility and the hospice agency.	A 020	Violation 7.8.2.20 D (1) The Facility will review all CURRENT resident files who are using hospice or home health services to ensure proper COORDINATION OF CARE documentation is in place. A) The Facility will retrieve evidence of R #4's coordination of care. Ongoing compliance will be conducted and monitored by house manager and administrator. To ensure FUTURE compliance, management will use the company approved "Resident Admission Checklist" for each admission to monitor ongoing compliance. This Violation will be corrected no later than 2-4-19.	

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A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (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.	A 026		

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A 026	Continued From page 11 [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (1) Based on observation, record review, and interview the facility failed to ensure for 3 (R #s 1, 4 and 5) of 5 (R #s 1-5) residents whose Individual Service Plans (ISPs) were reviewed for compliance included: 1. Care coordination with outside agencies on the ISP. 2. Assistance by Direct Care Staff (DCS) with escorting and monitoring for outside activities for residents with a diagnosis of dementia (Chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) with wondering behaviors. These deficient practices have the potential for residents to be at risk of harm and injury if the DCS: 1. Are not assisting residents who have a diagnosis of dementia with wondering behaviors who need an escort and monitoring for outside activities. 2. Do not know what care/services they are to provide and what the hospice agency will provide. The findings are: Findings for Escorting and Monitoring. A. On 10/01/18 at 3:20 pm, during an observation of the covered patio on the east side of the facility, it was observed that DCS #3, was	A 026	Violation 7.8.2.26 A (1) The facility will provide detailed information in the Individual Service Plan (ISP) and coordination of care for R #s 1,4, 5 and current and future residents and Direct Care Staff will assist residents with diagnosis with dementia 1) ISP's will be updated for residents with diagnosis of dementia to include that DCS will assist residents who have a diagnosis of dementia with wondering behaviors for outside who need an escort and monitoring activities 2) Coordination of care with outside agencies, hospice and home health on the ISP will be done as needed Ongoing compliance will be conducted and monitored by house manager and administrator by reviewing ISP's every 6 months or as needed when the resident has a change in condition. This Violation will be corrected no later than 2-4-19.	

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A 026	Continued From page 12 monitoring R #s 1 and 5 while they were sitting and then being escorted back into the facility. B. On 10/01/18 at 2:35 pm, during an interview with DCS #3, she stated that she escorts and sits with R #s 1 and 5 when they want to go out to the patio because they have dementia and they wander and are not safe. C. Record review of R #1's ISP (dated08/27/18) revealed, that it did not include assistance with escorts and monitoring for outside activities for R #1 who has a diagnosis of dementia with wandering behaviors. D. Record review of R #5's ISP (dated05/14/18) revealed, that it did not include assistance with escorts and monitoring for outside activities for R #5 who has a diagnosis of dementia with wandering behaviors. E. On 10/02/18 at 2:20 pm, during an interview with the House Manager, she confirmed that R #s 1 and 5 ISPs do not include assistance for residents who have a diagnosis of dementia with wandering behaviors that need escorting and monitoring for outside activities. Findings for Care of Coordination F. Record review of R #4's ISP (dated 07/17/18) who is receiving hospice services from an outside agency revealed, that it did not include documentation of coordination of care with the hospice agency. G. On 10/02/18 at 2:20 pm, during an interview with the House Manager, she confirmed that R #4's ISP did not include care coordination with the hospice agency.	A 026		

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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 nationality; (3) provide residents written information about all services provided by the facility and their costs	A 033		

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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 interaction and avoids social isolation;
(g) or their surrogate decision makers, are informed of and consent to the services provided

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A 033	Continued From page 15 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] This REQUIREMENT is not met as evidenced by:	A 033		

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7.8.2.33 D (4)

Based on record review, observation, and interview, the facility failed to ensure that they provided a safe environment for residents at the facility's outdoor areas. This deficient practice has the potential for all 12 (R #s 1-12) residents identified on the census provided by the House Manager on 10/01/18 to be at risk of mental and physical harm if the environment outside the facility is not safe. The findings are:

A. On 10/01/18 at 3:25 pm, during an observation of the patio on the east side of the building it was observed that:

1. The patio was not flush with the ground on:
   a. The edge of the patio on the south side which had a drop off of 7 inches to the ground.
   b. The edge of the patio on the east side which had a downwards slope a total of 16 feet to ground level.
   c. The edge of the sidewalk on the east side of the building which had a drop off of four and half inches to the ground.
2. There were no barriers around the patio to protect residents, if they were to trip or fall off the patio where the floor was not flush with the ground.

B. On 10/02/18 at 2:25 pm, during an observation of the outside of the building it was observed that:

1. There was no emergency lighting on the east, north, and west sides of the building to light the pathway around the building.
2. The sidewalk on the east side of the facility had 2-7 inch-wide and 10 inches deep holes in the sidewalk.

C. On 10/02/18 at 2:40 pm, during an interview

Violation 7.8.2.33 D (4)

The facility will provide residents (R#s 1-12) with a safe and sanitary living environment.

1. Patio on the EAST side of the building.

1. The entire patio and sidewalk on the east side of the building will receive fencing to ensure residents safety.
2. The fencing will protect residents from falling down the steep slope beyond the east side of the patio and the step and slope to the south as well as the step off of the sidewalk along the entire length of the building.

2. OUTSIDE EMERGENCY LIGHTING.

1. Emergency motion sensor lighting will be added on the east, north and west sides of the building to the pathway as needed.
2. Metal grates will be added to cover the crawl space ventilation holes in the sidewalk on the east side of the building.

Ongoing compliance will be conducted and monitored by house manager and administrator using the company approved "MAINTENANCE CHECKLIST" on a monthly basis to ensure that all exterior lighting is working properly for residents safety while walking at night or in the event of an emergency.

This Violation will be corrected no later than 2-4-19.

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A 033	Continued From page 17 with the House Manager, she confirmed that the patio on the east side of the building that: 1. The patio was not flush with the ground at: a. The edge of the patio on the south side which had a drop off at 7 inches to the ground. b. The edge of the patio on the east side which had a downwards slope a total of 16 feet to ground level. c. The edge of the sidewalk on the east side which had a drop off of four and half inches to the ground. 2. There were no barriers around the patio to protect residents if they were to trip or fall off the patio were the patio floor was not flush with the ground. 3. There was no emergency lighting on the east, north, and west sides of the building to light the pathway around the building. 4. The sidewalk on the east side of the building had 2-7 inch-wide and 10 inches deep holes in the sidewalk. Based on record review, observation, and interview, the facility failed to ensure that residents are able to come and go as they please without any restrictions. This deficient practice has the potential for all 12 (R #s 1-12) residents identified on the census provided by the House Manager on 10/01/18 to be at risk of mental harm if residents became isolated and are not allowed to make their own social decisions and of potential physical harm, injury, or death if they cannot exit the facility in the event of an emergency. The findings are: A. On 10/01/18 at 2:37 pm, during an observation, the West patio emergency exit door	A 033	The facility will remove deadbolts and install single motion handles on the EAST and WEST patio emergency exit doors. Residents will not be restricted from coming and going as they please. Ongoing compliance will be conducted and monitored by house manager and administrator using the company approved "MAINTENANCE CHECKLIST" on a monthly basis to ensure that the EAST and WEST patio emergency exit doors remain unlocked from means of egress to the outside and that they are working properly for residents safety in event of an emergency. This Violation will be corrected no later than 2-4-19.	

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was observed to be locked. It was also observed that the door had a dead bolt that was locked and a handle that was locked with a turn knob lock which did not release when handle was used. The exit/egress door is kept locked, does not have a single motion handle and has a deadbolt.

B. On 10/01/18 at 2:42 pm, during an interview with the house manager, she confirmed that the West patio emergency exit door is kept locked , that it had a dead bolt that was locked, and a handle that was locked with a turn knob lock, which did not release when the handle was used.

C. On 10/01/18 at 2:44 pm, during an observation, the East patio emergency exit/egress door to the patio was observed to be locked. It was observed that the door had a key dead bolt lock, that was not locked, a handle that was locked with a turn knob lock which did not release when the handle was used.

D. On 10/01/18 at 2:45 pm, during an interview with Direct Care Staff (DCS) #3, she confirmed that the East patio exit/egress door is kept locked at all times.

E. On 10/01/18 at 2:50 pm, during an interview with the House Manager, she confirmed thatthe East exit/egress door is kept locked, does not have a single motion handle and has a key deadbolt.

A 034 — 7 NMAC 8.2.34 Custodial Drug Permits — A 034

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

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A 034	Continued From page 19 have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (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	A 034		

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national fire protection association (NFPA) 99.
(8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document:
(a) the type and strength of the schedule II through IV drugs;
(b) the date and time staff assisted with self-administration;
(c) the resident ' s name;
(d) the prescriber ' s name;
(e) the dose;
(f) the signature of the person assisting with delivery of the medication; and
(g) the balance of medication remaining.
(9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC.
(10) The record of medication destruction shall 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

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A 034	Continued From page 21 of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7) Refer to: NFPA (National Fire Prevention Association) 99. 2012 Edition. 11.3 Cylinder and Container Storage Requirements. 11.3.1 * Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2 * Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any	A 034		

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A 034	Continued From page 22 flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation ofSprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fireprotection rating of 1/2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with5.1.3.5.12. 11.3.2.5 Cylinder and container storagelocations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection capsshall comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gascontainer storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be requiredto be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders	A 034		

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A 034	Continued From page 23 are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING Based on observation, record rewiew, and interview the facility failed to ensure that: 1. Oxygen cylinder tanks were secured and stored correctly. 2. Prescribed medications were available at the facility. This deficient practice has the potential for all 12 (R #s 1-12) residents identified on the census provided by the House Manager on 10/01/18, to be at risk of harm, injury, and/or require medical treatment if: 1. Oxygen cylinder tanks were to be knocked over and may act like a missile, and if a fire occurs, oxygen cylinder tanks stored with combustibles accelerates the fire. 2. Their prescribed medications are not available and taken as ordered.	A 034		

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A 034	Continued From page 24 The findings are: Findings related to oxygen A. On 10/02/18 at 2:48 pm, during an observation of the electrical room, 5 secured and 1 unsecured oxygen cylinder tanks were observed being stored with combustibles (cardboard boxes, can of gasoline, a can of paint) and the room was not vented to the outside. B. On 10/02/18 at 2:50 pm, during an interview with the House Manager, she confirmed that there were 5 secured and 1 unsecured oxygen cylinder tanks stored in the electrical room with combustibles (cardboard boxes, can of gasoline, and a can of paint) and the room was not vented to the outside. Findings related to medications C. On 10/03/18 at 11:15 am, observation and record review of R #3's MAR October 2018, revealed, that physicians order for medication Magnesium Citrate - Citroma (constipation) PRN (as needed) 1.745 gm (grams) by mouth, was observed not to be in the medication cart for immediate use. D. On 10/03/18 at 11:36 am, during aninterview with the House Manager, she confirmed that R #3's prescribed medication Magnesium Citrate - Citroma (constipation) PRN 1.745 gm take by mouth was not in the medication cart for immediate use.	A 034	Violation 7.8.2.34 A (7) The facility will ensure that, medical gases (oxygen), used for the administration of inhalation therapy shall comply with the national fire protection association (NFPA) 99. A) All Oxygen cylinders tanks will be secured and stored correctly, away from debris and flammable substances. B) Oxygen cylinder storage area will be vented to the outside of the facility by cutting a hole in the door to the storage room and placing ventilation hardware over the hole. C) MAR for R #3's Oct. 2018 physicians orders for medication Magnesium Citrate (constipation) PRN will be in the med cart for immediate use D) Physicians order will be on hand. Medication will be in med cart for Immediate use All Resident MAR's were reviewed to ensure that all medications are correct according to the doctors' orders. Ongoing compliance will be conducted and monitored by house manager and administrator by conducting "QUARTERLY MEDICATION REVIEWS" with the physician every 3 months to ensure that all medications are on hand and current according to doctors' orders. This Violation will be corrected no later than 2-4-19.	
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or	A 035		

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A 035	Continued From page 25 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. (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	A 035		

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A 035	Continued From page 26	A 035		

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;
(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);

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A 035	Continued From page 27 (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 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;	A 035		

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A 035	Continued From page 28 (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 (4-6) H N Based on observation, record review and interview the facility failed to ensure that: 1. The Medication Administration Record (MAR) was accurate and contained all the required information. 2. There are Physicians orders for over the counter medications. 3. Outdated medications were removed and discarded appropriately. This deficient practice has the potential to negatively affect the health and safety for all 12 (R #s 1-12) residents identified on the census provided by the House Manager on 10/01/18 to be at risk of harm if:	A 035	Violation 7.8.2.35 G (4-6) H N The facility will ensure that the Medication Administration Record (MAR) is accurate and will follow all Physician orders. 1) Information on MAR will be accurate and will include all required information to prevent medication errors 2) Medication taken will follow physician's orders. Monitored and supervised by the physician to ensure the resident is taking correct medication 3) Outdated medication will be removed from medication cart A) MAR, on R #1's will have name of the medication including the drug product brand name and the generic name B) MAR, on R #2's will have name of the medication including the drug product brand name and the generic name 2) Brand/generic and notation "C" for controlled meds will be noted 3) Will have physicians order for [redacted] C) R #3's MAR will reveal, blood sugar checks, glucose levels on a daily basis, also diagnosis for the medication of (dementia) and will have product brand name and the generic name D) MAR on R #4's will have name of medication including the drug product brand name and the generic name Continued on page 30...	

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A 035	Continued From page 29 1. Information on the MAR is not complete, accurate, and includes all required information, then medication errors could occur. 2. Medications are being taken without a physician's order and there are no directions, monitoring, or supervision by the physician to ensure the resident is taking the correct medications. 3. Outdated medications left in the medication cart, may not retain their effectiveness. The findings are: A. Record review of R #1's resident file and the 10/01/18 to 10/02/18 MAR revealed, it did not include the following required information: 1. Diagnosis for the medication 2. Brand/Generic names for the following medications: 3. Brand/Generic and diagnosis for the following medications:	A 035	All Resident MAR's were reviewed to ensure that, Doctors Orders for all OTC medications, Diagnosis, Brand/Generic names, notations such as "C" for controlled medications, and Dr. Ordered Blood Sugar Checks were put into the MAR as required by the State Health Department. Ongoing compliance will be conducted and monitored by house manager and administrator by using the company approved "Medications Received Checklist" when imputing medications in to the MAR to ensure all requirement are met. This Violation will be corrected no later than 2-4-19.	

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A 035	Continued From page 30 4. There were no physicians order for medication and the medication had expired on 09/27/15. B. Record review of R #2's resident file and the 10/01/18 to 10/02/18 MAR revealed, it did not include the following required information: 1. Brand/generic and diagnosis for the following medications: 2. Brand/generic and notation "C" for controlled medications was missing for 3. There were no physicians order for C. Record review of R #3's resident file and the 10/01/18 to 10/02/18 MAR revealed, the following required information: 1. Blood sugar checks were not on the MAR to record daily glucose levels. 2. Diagnosis for the following medications:	A 035		

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A 035	Continued From page 31 3. Brand/generic for the following medications: [redacted] 5. Brand/generic, diagnosis and route of delivery for the following medications: [redacted] D. Record review of R #4's resident file and the 10/01/18 to 10/02/18 revealed, it did not include the following required information: 1. Brand/generic for the following medications:	A 035		

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A 035	Continued From page 32 2. Brand/generic and diagnosis for the following medications: 3. Brand/generic and notation notation "C" for controlled medication for 4. Brand/generic, diagnosis, and notation "C" for controlled medication E. On 10/03/18 at 11:36 am, during an interview with the House Manager, she confirmed the the aboved listed missing information from R #s 1-4 resident files and the 10/01/18 to 10/02/18 MARs.	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 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	A 037		

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A 037	Continued From page 33 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 licensedfacilities 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, wellventilated 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 roomor cabinet. 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	A 037		

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A 037	Continued From page 34 cabinet. This deficient practice has the potential for all 12 (R #s 1-12) residents identified on the census provided by the House Manger on 10/01/18, 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 10/01/18 at 3:22 pm, during an observation of the unlocked laundry room, the following laundry and cleaning supplies were observed to be accessible to residents, some with dementia-memory loss. 1. (1) 33.8 oz (ounce) bottle of Fabric Softener. 2. (1) 138 oz bottle of Laundry Detergent. 3. (1) 121 oz Bottle of Bleach. B. On 10/01/18 at 3:26 pm, during an interview with the House Manager, she confirmed that the above listed laundry and cleaning supplies were in the unlocked laundry room and accessible to residents, some with dementia-memory loss.	A 037	Violation 7.8.2.37 A (10) The facility laundry supplies and cleaning supplies will not be kept in the same storage area used for the storage of food and clean storage and will be kept in a secured room or cabinet. A) The laundry room, where cleaning supplies will be kept, will be secured and locked at all times. Residents will not have access to any cleaning supplies. B) Cleaning supplies will be locked in laundry room and will not be accessible to any residents. C) Cleaning supplies will not be stored in the same area designated for the preparation of food.	
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and	A 038	Ongoing compliance will be conducted and monitored by house manager and administrator by using the company approved "Maintenance Checklist" to ensure door locks are working as required to keep cleaning products and chemicals secured. on a monthly basis Rec. cl - 1/29/19 This Violation will be corrected no later than 2-4-19.	

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A 038	Continued From page 35 away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 B C Based on observation and interview the facility failed to ensure cleaning supplies and chemicals were kept in secured rooms, closets, or cabinets. This deficient practice has the potential for all 12 (R #s 1-12) residents identified on the census provided by the House Manger on 10/01/18, to be at risk of harm or injury if they were to ingest or spill cleaning supplies or chemicals on their face or body. The findings are: A. On 10/01/18 at 3:00 pm, during an observation of the kitchen cabinets (unlocked), the following chemicals/cleaning supplies were observed to be accessible to residents, some with memory loss-dementia. 1. (1) 22 oz (ounce) bottle multipurpose cleaner 2. (1) 32 oz bottle of dishwashing soap 3. (1) Container of 21 automatic dishwasher detergent pods 4. (1) 116 oz bottle of bleach 5. (1) 26 oz spray bottle of window cleaner 6. (1) 22 oz spray bottle of bleach and water	A 038	Violation 7.8.2.38 B C The facility will ensure cleaning supplies and chemicals are kept in a secured room, closet, or cabinet to ensure that all (R #s 1-12) will not be harmed or injured A) All chemicals/cleaning supplies were removed from kitchen to a locked cabinet in laundry room, residents (1-12) will not have access to any chemicals/cleaning supplies B) The chemicals/cleaning supplies have been locked in laundry room. Resident will not have access. C) Chemicals/cleaning supplies are locked in the laundry room D) All chemicals/cleaning supplies have been locked in laundry room E) All chemicals, combustibles, and hazardous objects have been locked in housekeeping closet where residents do not have access. F) Housekeeping closet has been locked and all chemicals have been locked in closet only to be accessed by housekeeping staff. Ongoing compliance will be conducted and monitored by house manager and administrator by using the company approved "Maintenance Checklist" to ensure door locks are working as required to keep cleaning products and chemicals secured. on a monthly Basis - Per CP - 1/29/19 This Violation will be corrected no later than 2-4-19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED 10/03/2018

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A 038	Continued From page 36 mix B. On 10/01/18 at 3:04 pm, during an interview with the House Manager, she confirmed the chemicals/cleaning supplies listed above were left in unlocked kitchen cabinets and accessible to residents, some with dementia-memory loss. C. On 10/01/18 at 3:22 pm, during an observation of the laundry room (unlocked), the following chemicals/cleaning supplies were observed to be accessible to residents, some with dementia-memory loss. 1. (1) 33.8 oz bottle of fabric softener 2. (1) 138 oz bottle of laundry detergent. 3. (1) 121 oz bottle of bleach D. On 10/01/18 at 3:26 pm during an interview with the House Manager, she confirmed the chemicals/cleaning supplies listed above were left in the laundry room in unlocked cabinets. E. On 10/01/18 at 3:35 pm, during an observation of the unlocked housekeeping closet, the following chemicals, combustibles, and hazardous objects were observed to be accessible to residents, some with dementia-memory loss 1. (2) 12 oz spray cans of paint. 2. (1) 4.3 oz container of tile sealer. 3. (1) 1 3/4 oz tube of pipe thread sealant. 4. (1) 2 oz bottle of leak detector liquid. 5. (3) 10.5 oz tubes of caulking. 6. (1) 5.5 oz tube of caulking. 7. (1) 32 oz bucket of spackling. 8. (2) open packages of razor blades for glass and tile cutting. 9. (1) 10 lb bag of Ice melting chemical pellets.	A 038		

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BEEHIVE HOMES OF RATON	1465 TURNESA ST RATON, NM 87740

(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 038	Continued From page 37 F. On 10/01/18 at 3:35 pm, during an interview with the House Manager, she confirmed the housekeeping closet was unlocked, and the above listed chemicals, combustibles, and hazardous objects were observed to be accessible to residents, some with memory loss-dementia.	A 038	Violation 7.8.2.39 The facility will be maintained free from environmental and other factors that are detrimental to the residents and staff's health, safety, or welfare. 1) Patio east/west emergency exit door will remove both turn-knob and deadbolt and install single motion handle 2) Patio east/west will install railings and emergency lighting 3) West patio will add seating furniture (Patio Furniture) for residents to utilize the space for outdoor activities 4) Along the WEST patio we will install fencing around the patio to protect residents from a trip or a fall off of the patio/sidewalk. 5) East patio furniture, will make sure it is not blocking the exit walkway and placed in the proper way, away from any exit walkway 6) East patio will add a barrier around the patio to protect residents from a trip or a fall from the 4 to 7 inches uneven, slopes downward 7) The east patio exit walkway has (2) 7 inches wide x 14 inches long x10 inches deep open hole for venting the facility, located on the east wall, will be addressed 8) Residents independently will be allowed east/west patio, staff will also escort any resident with dementia-memory loss Continued on page 39...	
A 039	7 NMAC 8.2.39 Site Requirements SITE REQUIREMENTS: The facility shall be located and maintained free from environmental and other factors that are detrimental to the residents and staff's health, safety or welfare. The facility site shall be designed and maintained to encourage outdoor activities by the residents. [7.8.2.39 NMAC - Rp, 7.8.2.42 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.39 Based on observation and interview, the facility failed to insure that the (2) outdoor patio areas located on the East and West ends of the facility were free from environmental and structural factors that are detrimental to the residents' and staffs' health, safety, and welfare. The facility lacks safety railings and has structural issues (unlevel gravel, steep sloped yard, etc.) that present safety issues for residents participating in independent outdoor activities. These deficient practices have the potential for all 12 residents (R #s 1-12), as identified on the resident census provided by the House Manager on 10/01/18, to be at risk of being isolated/confined indoors, injured from environmental hazards, and tripping/falling hazards. The finding are:	A 039		

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A 039	Continued From page 38 A. On 10/01/18 at 2:37 pm, during an observation: 1. The West patio emergency exit door was locked with both a turn-knob handle lock and a deadbolt lock. 2. The patio and exit walkway had no railings attached. 3. The patio contained no seating or furniture items for residents to utilize the space for outdoor activities. 4. Structurally the patio rises approximately 4 and 5 inches above the unleveled gravel covered yard which slopes downward. 5. The exit walkway connected to, leading from the patio to the front of the facility had no railings or emergency lighting creating a potential tripping/falling hazard for the residents and staff. B. On 10/01/18 at 2:42 pm, during an interview with the House Manager, she confirmed that: 1. The West patio is an emergency exit route from the facility and the exit door was/is kept locked with both a turn-knob handle lock and deadbolt lock, preventing the door to be opened with 1 motion. 2. The patio and exit walkway hand no railings. 3. The patio contained no seating or areas for residents to utilize the space for outdoor activities. 4. Structurally the patio rises approximately 4 and 5 inches above the unleveled gravel covered yard which slopes downward. 5. The exit walkway connected to, leading from the patio to the front of the facility had no railings or emergency lighting creating a potential tripping/falling hazard for the residents and staff.	A 039	Ongoing compliance will be conducted and monitored by house manager and administrator by using the company approved "Maintenance Checklist" to ensure that, emergency exit doors are - functioning properly for means of egress at all times, Fencing and emergency lighting are in good working order, grates that cover crawl space ventilation are secure, and patio furniture is neat and organized. This Violation will be corrected no later than 2-4-19.	on a monthly basis cp. per 1-29-19

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A 039	Continued From page 39 C. On 10/01/18 at 2:44 pm, during an observation and interview with the House Manager, the East patio exit door to the patio door was observed to be locked. Direct Care Staff (DCS # 3) was observed at the door, unlocking it for a resident to go outside. It was observed that the East patio is an emergency exit route from the facility and that the exit door is kept locked, does not have a single motion handle, and has a key deadbolt. The observation was confirmed by the House Manager. D. On 10/01/18 at 2:45 pm, during an interview with DCS #3, she confirmed that: 1. The East patio exit door is kept locked and that the staff have to unlock the door for residents (some with dementia-memory loss) while utilizing the outdoor patio space due to safety issues. 2. The residents (cognitively (thinking, reasoning, remembering) intact) are not allowed to be outside on the patio independently without a staff member staying with them at all times 3. Upon reentering the building the exit door is locked E. On 10/01/18 at 2:47 pm, during an observation of the East patio the following was observed: 1. Patio furniture was blocking the exit walkway. 2. The exit walkway attached to the patio and the patio were without railings. 3. The patio structurally rises approximately 4" to 7" inches above gravel covered ground surrounding the walkway which is uneven and slopes significantly downward. 5. The exit walkway connected to the patio which leads from the patio to the front of the facility has no railing or emergency lighting. 6. The walkway has two (2) approximately 7	A 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 039	Continued From page 40	A 039		

inch wide x 14 inches long x 10 inch deep open holes for venting the facility's below ground level crawlspace. The holes are located at the base of the vertical East wall and open out horizontally into the cement walkway.

F. On 10/01/18 at 2:50 pm, during an interview with the House Manager, she confirmed that:

1. Patio furniture was blocking the exit walkway.
2. The exit walkway attached to the patio and the patio were without railings.
3. The patio structurally rises approximately 4" to 7" inches above gravel covered ground surrounding the walkway which is uneven and slopes significantly downward.
5. The exit walkway connected to the patio which leads from the patio to the front of the facility has no railing or emergency lighting.
6. The walkway has two (2) approximately 7 inch wide x 14 inches long x 10 inch deep open holes for venting the facility's below ground level crawlspace. The holes are located at the base of the vertical East wall and open out horizontally into the cement walkway.

The East patio is an emergency exit route was locked and staff had to unlock it for residents to go outdoors.

7. That residents are not allowed to use the East patio independently without the presence of a staff member

G. On 10/02/18 2:25 pm, during an observation of the sidewalk on the East side of the facility (2) approximately 7 inch wide x 14 inches long x 10 inches deep open holes for venting the facility's below ground level crawlspace were observed. The holes were located at the base of the vertical East wall and open out horizontally into the cement walkway create a tripping hazard.

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A 039	Continued From page 41 H. On 10/02/18 at 2:40 pm, during an interview with the House Manager she confirmed the (2)7 inch wide x 14 inches long x 10 inches deep open holes for venting the facility's below ground level crawlspace located at the base of the vertical East wall open out horizontally into the cement walkway were observed and were a tripping hazard.	A 039		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 A B Based on observation and interview, the facility failed to ensure that the grounds were free of safety/tripping hazards. This deficient practice has the potential for all 12 (R #s 1-12) residents identified on the census provided by the House	A 042		

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A 042	Continued From page 42 Manager on 10/01/18, to be at risk of being injured, if they were to trip and/or fall, because of the holes in the sidewalks. The findings are: A. On 10/02/18 at 2:25 pm, during an observation of the sidewalk on the East side of the facility (2) 7-inch-wide, 14-inches long, and 10-inches-deep holes were observed in the sidewalk. B. On 10/02/18 at 2:40 pm, during an interview with the House Manager, she confirmed that there were (2) 7 inch-wide, 14-inches wide, and 10-inch deep holes on the sidewalk on the East side of the property.	A 042	Violation 7.8.2.42 A B The facility will cover the crawlspace ventilation holes with grates that will provide a stable and presentable walking path on the east side of the building. Ongoing compliance will be conducted and monitored by house manager and administrator by using the company approved "Maintenance Checklist" on a monthly basis to ensure the grates that cover crawl space ventilation are secure and safe from trip hazard.	
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff , and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service.	A 047	This Violation will be corrected no later than 2-4-19.	

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A 047	Continued From page 43 F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.47 E Based on observation and interview, the facility failed to ensure that emergency lighting was on the exterior of the facility of the building. This deficient practice has the potential for all 12 (R #s 1-12) residents identified on the census provided by the House Manager on 10/01/18 and all occupants of the building, to be at risk of harm or injuries if there is a power outage or an emergency that requires evacuation if exits do not have sufficient lights to see when exiting the building. The findings are: A. On 10/02/18 at 2:25 pm, during an observation of the outside of the facility, it was observed that there were no outside emergency lighting on the East, North, and West sides of the building to light the pathway/sidewalk around the building. B. On 10/02/18 at 2:40 pm, during an interview with House Manager, she confirmed that there were no emergency lighting on the East, North, and West sides of the building to light the pathway/sidewalk around the building.	A 047	Violation 7.8.2.47 E OUTSIDE EMERGENCY LIGHTING. Emergency motion sensor lighting will be added on the east, north and west sides of the building to the pathway as needed. Ongoing compliance will be conducted and monitored by house manager and administrator using the company approved "MAINTENANCE CHECKLIST" on a monthly basis to ensure that all exterior lighting is working properly for residents safety while walking at night or in the event of an emergency. This Violation will be corrected no later than 2-4-19.	
A 049	7 NMAC 8.2.49 Doors	A 049		

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A 049	Continued From page 44 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 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	A 049		

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A 049	Continued From page 45 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) (2) F Based on observation and interview, the facility failed to ensure that the West and East emergency doors are unlocked and could be opened by any occupant, without the use of a key, or any special knowledge from the inside when locked. This deficient practice has the potential for all 12 (R #s 1-12) residents on the census, provided by House Manager on 10/01/18, 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 2:37 am, during an observation, the West patio emergency exit door was observed to be be locked with a deadbolt lock and could not be opened with 1 motion to exit the building to go outside on the patio or evacuate the building. B. On 10/01/18 at 2:42 pm, during an interview with the House Manager, she confirmed thatthe West patio emergency exit door was locked with a deadbolt lock and could not be opened with 1 motion to exit the building to go outside on the patio or evacuate the building. C. On 10/18/18 at 2:44 pm, during an	A 049	The facility will remove deadbolts and install single motion handles on the EAST and WEST patio emergency exit doors. Residents will not be restricted from coming and going as they please. Ongoing compliance will be conducted and monitored by house manager and administrator using the company approved “MAINTENANCE CHECKLIST” on a monthly basis to ensure that the EAST and WEST patio emergency exit doors remain unlocked from means of egress to the outside and that they are working properly for residents safety in event of an emergency. This Violation will be corrected no later than 2-4-19.	

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A 049	Continued From page 46 observation with the House Manager, the East patio exit door the following was observed: 1 The door was locked with a turn-knob handle lock and key lock deadbolt that requires more than a single motion to open. 2. Direct Care Staff (DCS #3) was observed having to unlock the door so R #1 could go outside onto the patio. D. On 10/01/18 at 2:45 pm, during an interview with DCS #3, she confirmed that the East patio exit door is: 1. Locked with turn-knob handle lock and a key lock deadbolt that requires more than a motion to open. 2. Kept locked and staff have to unlock the door for residents to exit the building to go outside on the patio or evacuate thebuilding. E. On 10/01/18 at 2:50 pm, during an interview with the House Manager she confirmed that the East exit patio door is kept locked and that the staff have to unlock the door for residents to exit the building to go outside on the patio or evacuate the building.	A 049		
A 050	7 NMAC 8.2.50 Exits EXITS: A. The facility shall have at least two (2) approved exits, that do not involve windows and which are remote from each other. B. Facilities with ten (10) or more residents shall have each exit clearly marked with lighted signs having letters at least six (6) inches high and at least three-quarters (3/4) of an inch wide. Exit signs shall be visible at all times. C. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for	A 050		

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A 050	Continued From page 47 use in lieu of electrically interconnected emergency lighting. D. Exits shall be clear of obstructions at all times. E. Exits, exit paths, or means of egress shall not pass through hazardous areas, garages, storerooms, closets, utility rooms, laundry rooms, bedrooms, or spaces subject to locking. F. For facilities with four (4) or more residents, sliding doors are not acceptable as a required exit. EXCEPTION: Assisted living facilities with three (3) or fewer residents may have sliding doors as required exits. G. When the yard gate(s) is part of the exit access and is locked, the gate shall be connected to the fire protection system and release upon activation of the fire/smoke system or shall have the ability to be unlocked at the gate site. [7.8.2.50 NMAC - Rp, 7.8.2.51 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.50 E Based on observation and interview, the facility failed to ensure that the West and East emergency exit paths did not pass through potentially hazardous areas with potential tripping/falling risks, and that the emergency exit doors are not subject to locking. This deficient practice has the potential for all 12 (R #s 1-12) residents on the census provided by House Manager on 10/01/18, to be at risk of injury or harm if they are not able to safely exit/evacuate the building by choice or if a fire or other emergency requiring evacuation were to occur. The findings are: A. On 10/01/18 at 2:37 pm, during observation	A 050		

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A 050	Continued From page 48	A 050		

the following was observed:

1. The West patio emergency exit door was locked with both a turn-knob handle lock and a deadbolt lock.
2. The patio and exit walkway had no railings attached.
3. The patio contained no seating or furniture items for residents to utilize the space for outdoor activities.
4. Structurally the patio rises approximately 4 and 5 inches above the unleveled gravel covered yard which slopes downward.
5. The exit walkway connected to, leading from the patio to the front of the facility had no railings or emergency lighting creating a potential tripping/falling hazard for the residents and staff.

B. On 10/01/18 at 2:42 pm, during an interview with the House Manager, she confirmed that:

1. The West patio is an emergency exit route from the facility and the exit door was/is kept locked with both a turn-knob handle lock and deadbolt lock, preventing the door to be opened with 1 motion.
2. The patio and exit walkway had no railings.
3. The patio contained no seating or areas for residents to utilize the space for outdoor activities.
4. Structurally the patio rises approximately 4 and 5 inches above the unleveled gravel covered yard which slopes downward.
5. The exit walkway connected to, leading from the patio to the front of the facility had no railings or emergency lighting creating a potential tripping/falling hazard for the residents and staff.

C. On 10/01/18 at 2:44 pm, during observation with the House Manager the following potential hazards to staff and resident, some with memory loss/dementia:

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	4033	A. BUILDING: ________ B. WING ________	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF RATON	1465 TURNESA ST RATON, NM 87740

(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 050	Continued From page 49	A 050		

1. The East patio emergency exit door to the patio was locked with a turn knob which did not release the handle was turned and a keyed dead bolt.
2. Direct Care Staff DCS#3) was observed at the East door unlocking it for R #1 to go outside on the patio.
3. The patio furniture blocked the exit pathway.
4. The patio had no railing.
5. The patio structurally rises approximately 4" to 7" inches above gravel covered ground around it which is uneven and slopes significantly downward.
6. The exit walkway connected to the patio which leads from the patio to the front of the facility has no railing.
7. The exit walkway has no emergency lighting.
8. The walkway also has two (2) approximately 7 inch wide x 14 inches long x 10 inch deep open holes for venting the facility crawlspace located at the base of the vertical East wall and open out into the horizontal cement walkway.

D. On 10/01/18 at 2:45 pm, during an interview with DCS #3, she confirmed that:

1. The East patio exit door is kept locked and that the staff have to unlock the door for residents (some with dementia-memory loss) while utilizing the outdoor patio space due to safety issues.
2. The residents (totally cognizant) are not allowed to be outside on the patio independently without a staff member staying with them at all times
3. Upon reentering the building the exit door is locked

E. On 10/01/18 at 2:50 pm, during an interview

Division of Health Improvement

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BEEHIVE HOMES OF RATON	**1465 TURNESA ST RATON, NM 87740**

(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 050	Continued From page 50 with the House Manager, she confirmed the following potential hazards to staff and resident , some with memory loss/dementia: 1. The East patio emergency exit door to the patio was locked with a turn knob which did not release the handle was turned and a keyed dead bolt. 2. DCS # 3 observed at the East door unlocking it for a R #1 to go outside on the patio. 3. The patio furniture blocked the exit pathway. 4. The patio had no railing. 5. The patio structurally rises approximately 4" to 7" inches above gravel covered ground around it which is uneven and slopes significantly downward. 6. The exit walkway connected to the patio which leads from the patio to the front of the facility has no railing. 7. The exit walkway has no emergency lighting. 8. The walkway also has two (2) approximately 7 inch wide x 14 inches long x 10 inch deep open holes for venting the facility crawlspace located at the base of the vertical East wall and open out into the horizontal cement walkway.	A 050	Violation 7.8.2.50 E 1. The facility will remove deadbolts and install single motion handles on the EAST and WEST patio emergency exit doors. Residents will not be restricted from coming and going as they please. 2. Fencing will be installed around the patios and down the sidewalks on both the EAST and WEST sides of the building. 3. Emergency Motion Censored Lighting will be installed on both EAST and WEST sides of the building and the NORTH as needed. 4. Patio furniture will be rearranged so that it does not block the door or walkways in the event of an emergency. 5. Metal grates will be added to cover the crawl space ventilation holes in the sidewalk on the east side of the building. Ongoing compliance will be conducted and monitored by house manager and administrator using the company approved "MAINTENANCE CHECKLIST" on a monthly basis to ensure that, the EAST and WEST patio emergency exit doors remain unlocked from means of egress to the outside and that they are working properly for residents safety in event of an emergency, Fencing is in good repair, Emergency Motion Lighting are working properly, Patio furniture is neat and out of the pathways to egress in case of an emergency, and grates are durable and not posing a trip hazard. This Violation will be corrected no later than 3-1-19.	
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply.	A 068		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF RATON	1465 TURNESA ST RATON, NM 87740

(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 068	Continued From page 51 (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of	A 068		

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A 068	Continued From page 52 the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals	A 068		

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A 068	Continued From page 53 that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with	A 068		

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A 068	Continued From page 54 regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuantto 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes inthe resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include theresident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right toschedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal orformal depending on the nature of theissue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility	A 068		

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A 068	Continued From page 55 that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.68 C (2) Based on record review and interview the facility failed to ensure for 1 (R #4) of 1 (R #4) resident identified on the resident census as receiving hospice services that the Individual Service Plan (ISP) has evidence of care coordination with the hospice agency. This deficient practice has the potential for the residents who have elected to receive hospice services to be at risk of harm if the Direct Care Staff (DCS) do not know what services they are to provide and what services the hospice agency will provide. The findings are: A. Record review of R #4's ISP (dated 07/17/18) revealed, that it did not include hospice services	A 068	7 NMAC 8.2.68 Hospice The Facility will review all CURRENT resident files who are using hospice or home health services to ensure proper COORDINATION OF CARE documentation is in place. A) The Facility will retrieve evidence of R #4's coordination of care. Ongoing compliance will be conducted and monitored by house manager and administrator. To ensure FUTURE compliance, management will use the company approved "Resident Admission Checklist" for each admission to monitor ongoing compliance. This Violation will be corrected no later than 2-4-19.	

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A 068	Continued From page 56 or show the coordination of care between the facility and the hospice agency. B. On 10/02/18 at 2:20 pm, during an interview with the House Manager, she confirmed that R #4's ISP did not include care coordination between the facility and the hospice agency.	A 068		
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 by: 7.8.2.70 E 2. Refer to 7.1.12 EMPLOYEE ABUSE	A 070		

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A 070	Continued From page 57 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 reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying	A 070		

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A 070	Continued From page 58 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. [7.1.12.8 NMAC - N, 01/01/2006] Based on record review and interview the facility	A 070		

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A 070	Continued From page 59 failed to ensure that Direct Care Staff of 2 (R #s 1-2) of 4 (R #s 1-4) staff whose filed were reviewed had been cleared by the Employee Abuse Registry (EAR) prior-to-hire. This deficient practice has the potential to negatively affect the safety and welfare of all residents listed on the census provided by the house Manager on 10/01/18 if they are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents or have a felony conviction. The findings are: A. Record review of DCS #1's employee file revealed, a hire date of 05/31/18 and the EAR was not submitted until 06/06/18 and the Final Registry Summary is missing the EAR clearance page B. Record review of DCS #2's employee file revealed, a hire date of 01/02/18 and the EAR was not submitted until 01/17/18. C. On 10/02/18 at 11:24 am, during an interview with the House Manager, she confirmed for DCS #s 1 & 2 that the EARs were not submitted and clearances received prior to hire. In addition, the House Manager confirmed that DCS #1's Final Registry Summary is missing the EAR clearance page.	A 070	Violation 7.8.2.70 E (3) The facility will ensure that all CURRENT and FUTURE employees have been processed and cleared through the EMPLOYEE ABUSE REGISTRY. A) Requirement to inquire of registry prior to employment B) Prohibited employment C) Applicant's identifying information required D) Documentation of inquiry to registry E) Documentation for other staff F) Consequences of noncompliance All employee files were reviewed to ensure that employees have been processed and cleared through the EMPLOYEE ABUSE REGISTRTY. All required documentation has been placed in employee files. Ongoing compliance will be conducted and monitored by house manager and administrator. Management will use the company approved "New Hire Checklist" to monitor ongoing compliance. This Violation will be corrected no later than 2-4-19.	