

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/09/2023
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF VOLCANO CLIFFS			STREET ADDRESS, CITY, STATE, ZIP CODE 6230 MONTANO RD NW ALBUQUERQUE, NM 87120		
(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 during a Full-Onsite/Complaint survey completed on [REDACTED] 23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities for Adults. Census (15) Complaint Intake [REDACTED] was investigated with no deficiencies cited. Abbreviations: lb - Pound fl oz - Fluid Ounce oz - Ounce gal - Gallon ML - Milliliter USP - United States Pharmacopeia MG - Milligrams	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;	A 016			

Division of Health Improvement

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

TITLE

(X6) DATE

Gwelyn Motteng

Administrator

8-30-23 ~~06/23/23~~

Division of Health Improvement

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A 016	Continued From page 1 (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 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	A 016			

Division of Health Improvement

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF VOLCANO CLIFFS

**6230 MONTANO RD NW
ALBUQUERQUE, NM 87120**

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A 016	Continued From page 2 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: 7.8.2.16 B (3) (7) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A	A 016		

Division of Health Improvement

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A 016	Continued From page 3 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 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.	A 016			

Division of Health Improvement

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A 016	Continued From page 4 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] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: ... D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the	A 016		

Division of Health Improvement

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A 016	Continued From page 5 nationwide and statewide criminal history screening investigation shall not exceed seventy-four (\$74) dollars. Of which, twenty-four (\$24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven (\$7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. ... E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules.	A 016			

Division of Health Improvement

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A 016	Continued From page 6 The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility failed to ensure that Direct Care Staff (DCS): 1. Were cleared by the Employee Abuse Registry (EAR) prior-to-hire. 2. Applications and fingerprints were submitted to the Caregiver Criminal History Screening	A 016			

Division of Health Improvement

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A 016	Continued From page 7 Program (CCHSP) within 20 days of hire. This deficient practice could negatively affect the safety and welfare of the [REDACTED] residents identified on the resident census, provided by the Administrator on [REDACTED] 23, if they are being provided care by staff who may have a previous history of abusing, neglecting, or exploiting residents; or may be a convicted felon. The findings are: A. Record review of the Administrator's staff file (hire date: [REDACTED] 22), revealed the: 1. EAR clearance was received on [REDACTED] 22 and not prior to hire. 2. Fingerprints and CCHSP application were not submitted within 20 days of hire and letter of clearance was dated [REDACTED] 22. B. Record review of the DCS#3's staff file (hire date: [REDACTED] 23), revealed the: 1. EAR clearance was received twice: on [REDACTED] 23 and again on [REDACTED] 23, but not prior to hire. 2. Fingerprints and CCHSP application were not submitted within 20 days of hire and letter of clearance was dated [REDACTED] 23. C. On [REDACTED] 23 at 12:31pm, during an interview with the Administrator, she confirmed that for herself and DCS #3 the: 1. EAR clearances were not received prior to hire. 2. Fingerprints and CCHSP applications were not submitted within 20 days of hire.	A 016	(A016) An EAR clearance will be obtained for all direct care staff prior to hire and kept on file at the facility. Fingerprints and CCHSP application will be submitted within 20 days of hire for all direct care staff. The house manager will ensure that this is followed and that documentation of timely compliance is kept in the facility's records.	06/23/23	
A 017	7 NMAC 8.2.17 Staff Training	A 017			

Division of Health Improvement

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A 017	Continued From page 8 STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled,	A 017		

Division of Health Improvement

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A 017	Continued From page 9 including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A C Based on record review and interview, the facility failed to ensure that Direct Care Staff (DCS) received: 1. A minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents 2. Twelve (12) hours of orientation and annual training required by regulation. This deficient practice could likely result in the [REDACTED] residents identified on the census provided by the Administrator on [REDACTED] 23, to be at risk for harm, illness, or injury, if the DCS providing care have not received all required training and do not know how to properly care for residents. The findings are: A. Record review of DCS #2's (date of hire: [REDACTED] 2021) training records revealed, no documentation showing that the following trainings were received/completed: 1. For the Orientation Training Record dated 2021, a. Fire safety and evacuation training b. Reporting requirements for abuse, neglect, or exploitation in accordance with 7.1.13 NMAC c. Smoking policy for staff, residents, and visitors d. Emergency procedures	A 017	(A017) All direct care staff will be provided with 16 hours of supervised training upon hire and 12 hours of training annually on topics prescribed by regulation. This training will be documented on the employees' files. Employee #3 did receive 16 hours of supervised training but it was not documented; this is now documented in the employee's file. All current employees have completed training and are current for 2023. The house manager will ensure that this training is complete and documented, and will review annual training as part of each employee's performance evaluation to ensure ongoing compliance.	06/30/23

Division of Health Improvement

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A 017	Continued From page 10 e. Safe food handling f. Methods of Quality of Care g. Medication assistance h. Infection control g. Implementing the resident's Individual Service Plan (ISP) 2. There was no documentation showing that annual trainings were received for 2022. B. On [REDACTED]/23 at 12:41 pm, during an interview with the Administrator, she confirmed, there was no documentation that DCS #2 received/completed the trainings listed above for at orientation for 2021 or annual trainings for 2022. C. Record review of DCS #3's (date of hire: [REDACTED]/23) training records revealed, there was no documentation showing that the sixteen (16) hours of supervised training was received. D. On [REDACTED]/23 at 12:41 pm, during an interview with the Administrator, she confirmed that there was no documentation of the sixteen (16) hours of supervised trainings for DCS #3.	A 017		
A 023	7 NMAC 8.2.23 Pets PETS: Pets are permitted in a licensed facility, in accordance with the facility's rules. A. Prohibited areas. Animals are not permitted in food processing, preparation, storage, display and serving areas, or in equipment or utensil washing areas. Guide dogs for the blind and deaf and service animals for the handicapped shall be permitted in dining areas pursuant to Subsection K of 7.6.2.9 NMAC. B. Vaccination. Pets shall be vaccinated in accordance with all state and local requirements	A 023		

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A 023	Continued From page 11 and records of such vaccination shall be kept on file in the facility. [7.8.2.23 NMAC - Rp, 7.8.2.24 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.23 B Based on record review and interview, the facility failed to ensure that pets (dogs) living in the facility had current vaccination records on file at the facility. This deficient practice has the potential for all [REDACTED] residents listed on the census provided by the Administrator on [REDACTED]/23 to be a risk of harm or illness, if the residents are bitten or contract communicable diseases from the animal that does not have current vaccinations. The findings are: A. Record review of vaccination records (dated: [REDACTED] 17), for the one (1) dog living in the facility, revealed the vaccine (Rabies) was expired and not up to date. B. On [REDACTED] 23 at 11:50 am, during an interview with the Administrator, she confirmed that the dog's vaccination records were not up-to-date.	A 023	(A023) Current vaccination records will be maintained on file at the facility for any pets. A current vaccination is on file for the pet referenced. The house manager will ensure that pet vaccinations are current and documented.	06/25/23
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance	A 032		

Division of Health Improvement

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A 032	Continued From page 12 with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) and B 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2)	A 032			

Division of Health Improvement

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF VOLCANO CLIFFS

**6230 MONTANO RD NW
ALBUQUERQUE, NM 87120**

(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 032	Continued From page 13 W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor 's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure for 1 (R #3) of 3 (R #s 1-3) residents whose Internal Incident Reports were reviewed for compliance that: 1. The facility reported incidents of unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority complaint hotline within twenty-four (24) hours or by the next	A 032		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/09/2023
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF VOLCANO CLIFFS			STREET ADDRESS, CITY, STATE, ZIP CODE 6230 MONTANO RD NW ALBUQUERQUE, NM 87120		
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A 032	Continued From page 14 business day, if it is a weekend or a holiday. 2. The facility conducted an internal investigation and submitted an investigation follow-up report to the Licensing Authority within five (5) business days from the date an incident occurred. These deficient practices could likely result in the residents to be at risk of harm, injury, and/or death; if incidents occur and there is no oversight by the Licensing Authority. The findings are: A. Record review of R #3's Internal Incident Report (dated [REDACTED]/22) revealed: 1. At 3:30 am, R#3 called out for help and was on [REDACTED] crying and yelling [REDACTED] can't get up. 2. DCS#5 arrived in the R#3's room and R#3 told [REDACTED] that [REDACTED] hurting but was not specific as to where. 3. DCS#5 notified DCS#1 and advised her that R#3 has a right hip problem but has not gotten the results back from the doctor. 4. 911 was called and R#3's sister was notified. B. On [REDACTED] 23 at 2:03 pm, during an interview with DCS#1, she confirmed: 1. R#3 was sent out to the hospital but that no injury determined at the hospital. 2. R#3 has a history of hip surgery and was prescribed [REDACTED] for her back and hip on [REDACTED] 22. 3. They are not aware of any falls prior to R#3 being sent out to the hospital on [REDACTED] 22. 4. The incident on [REDACTED] 22 was not common or usual for R#3; and [REDACTED] does not normally call out for help and complain about having pain. 5. R#3 was diagnosed with [REDACTED] when [REDACTED] was sent out to the hospital. 6. DCS #1 does not recall if the incident on	A 032	(A032) Incidents of unusual occurrence will be investigated, documented, and reported to the licensing authority within 24 hours or by the next business day. For any incident so reported, a follow-up report will also be made to the licensing authority within 5 days of the incident. The house manager and the Administrator will be responsible for identifying, investigating, and reporting any resident unusual occurrence that has or could threaten the health, safety of the residents and staff.	06/30/23	

Division of Health Improvement
STATE FORM

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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ALBUQUERQUE, NM 87120**

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A 032	Continued From page 16 follow-up report to the Licensing Authority within five (5) business days from the date of the incident.	A 032		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (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.	A 034		

Division of Health Improvement

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A 034	Continued From page 17 (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall 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	A 034		

Division of Health Improvement

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A 034	Continued From page 18 consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (4) (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	A 034		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 034	Continued From page 19 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 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 of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations 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 caps shall comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container 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)	A 034		

Division of Health Improvement

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A 034	Continued From page 20 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 required to 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 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 (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. Based on observation and interview, the facility failed to ensure that: 1. Oxygen cylinder tanks were stored securely and protected from accidental damage and separated from combustibles or materials. 2. All medications, including non-prescription	A 034		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 034	Continued From page 21 drugs, were stored in a locked compartment or in a locked room, as approved by the board of pharmacy. These deficient practices could likely result in the [REDACTED] residents identified on the census provided by the Administrator on [REDACTED] 23, to be at risk of harm, injury, or death if: 1. Oxygen cylinder tanks were to fall over damaging the valve, causing them to depressurize during a fire, the oxygen feeds the fire, causing it to spread faster and/or the cylinder tanks act like missiles and hit a resident/staff/rescuer during a fire. 2. Unsecured self-administered medications are stored in unlocked cart were readily accessible to other residents, staff, or visitors. The Findings related to the oxygen cylinder tanks are: A. On [REDACTED] 23 at 12:10 pm, during observation of the facility's designated oxygen room, the following was observed: 1. Three (3) small oxygen tanks were not secured or protected from falling over. 2. Two (2) mop rags were thrown on top of one small oxygen tank, causing it to fall over. 3. Four (4) large oxygen tanks were covered with one (1) large mop rag. 4. The following combustible materials and chemicals were being stored next to the oxygen tanks: a. One (1) fifteen count box of all purpose cleaning pads. b. Three (3) one lb containers of disinfectant wipes. c. Two (2) 19 oz bottles of disinfectant spray. d. One (1) 32 fl oz bottle of hydrogen peroxide. e. Two (2) 14.2 oz cans of enhancing polish.	A 034		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF VOLCANO CLIFFS		STREET ADDRESS, CITY, STATE, ZIP CODE 6230 MONTANO RD NW ALBUQUERQUE, NM 87120		
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A 034	Continued From page 22 f. Three (3) 19 oz cans of glass cleaner. g. One (1) 32 fl oz bottles of disinfect glass cleaner. h. Two (2) 122 fl oz bottles of bleach. i. One (1) unknown size bottle of glass cleaner j. Two (2) 32 fl oz bottles of toilet bowl cleaner. k. One (1) 32 oz bottle of disinfect cleaner. l. One (1) 25 oz can of bathroom cleaner. m. Two (2) 1 gal bottle of multipurpose cleaner. B. On [REDACTED] 23 at 2:18 pm, during an interview with the House Manager, she confirmed the oxygen tanks were unsecured and not protected from falling over; and the storage of the combustibles and chemicals located in the room and near the oxygen tanks. The Findings related to the unsecured medications are: C. On [REDACTED] 23 at 11:43 am, during an observation of the facility's medication room, revealed: 1. The door to the medication room was open. 2. The refrigerator utilized to store current medication was unlocked and accessible to residents. 3. The following medications were observed unsecured in the unlocked medication refrigerator: a. [REDACTED] b. [REDACTED] c. [REDACTED] d. [REDACTED] e. [REDACTED]	A 034	(A034) Oxygen cylinders will be stored securely and separated from combustibles or materials. The oxygen cylinders in the example were secured the date of the survey and empty cylinders were returned to the supplier. The medication refrigerator lock was repaired during the survey, as noted. All medications in the medication room will be stored securely and the house manager will monitor this daily. Any needed repairs will be made promptly.	06/09/23

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 034	Continued From page 23 f. [REDACTED] g. [REDACTED] h. [REDACTED] i. [REDACTED] j. [REDACTED] D. On [REDACTED] 23 at 12:47 pm, during an interview with the House Manager, she confirmed: 1. The lock on the medication refrigerator broke last week (unspecified date) and another lock has been ordered. 2. The medications are unsecured at this time and the door to the medication room remains open. E. On [REDACTED] 23 at 8:40 am, during an interview with the House Manager, she confirmed that they replaced the lock and key to the medication refrigerator. It is now secured. F. On [REDACTED] 23 at 9:00 am, during an observation of the facility medication room, revealed the refrigerator utilized to store current medication was locked.	A 034		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the "recommended daily dietary allowance" of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 036	Continued From page 24 accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to	A 036		

Division of Health Improvement

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A 036	Continued From page 25 eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place	A 036		

Division of Health Improvement

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A 036	Continued From page 26 protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store,	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF VOLCANO CLIFFS

**6230 MONTANO RD NW
ALBUQUERQUE, NM 87120**

(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 036	Continued From page 27 prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 036	Continued From page 28 regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as "additives" in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010]	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 036	Continued From page 29 This REQUIREMENT is not met as evidenced by: 7.8.2.36 A 1(b) C 4 D 3 5 8 (b) Based on observation, record review, and interview, the facility failed to ensure: 1. Available snacks were posted on the daily menu and posted where residents and families were able to view it. 2. All garbage and kitchen refuse that is not disposed of through a garbage disposal unit, shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. 3. Food stored in refrigerators and freezers were covered, dated, and labeled. 4. Medication, biological specimens, poisons, detergents, and cleaning supplies shall not be kept in the same storage areas used for storage of foods. 5. The temperature for all hot foods was maintained at one hundred forty (140) degrees Fahrenheit. These deficient practices could likely cause the [REDACTED] residents listed on the census provided by the Administrator on [REDACTED]/23, to be at risk for harm, or illness/death from foodborne illnesses if: 1. They do not know if, when, and what snacks of nourishing quality are available. 2. Food becomes contaminated with germs and bacteria, because the trash cans do not have tight fitting lids. 3. Food, was not stored properly (dated and labeled), and leftovers were kept longer than three (3) days after being served the first time. 4. Detergents and cleaning supplies are mixed	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 036	Continued From page 30 with foods and they are accidentally ingested by residents when eating. 5. The hot food is not maintained at 140 degrees and the residents consume foods that are not served at safe temperatures. The findings are: A. On 06/09/23 at 10:40 am, during an observation of the facility's kitchen revealed: 1. The facility's posted menu did not list available snacks for residents. 2. One (1) garbage can did not have a tight fighting lid. 3. The following items were located in the kitchen freezer and undated: a. one (1) unknown quantity of frozen fish sticks stored in a plastic bag b. one (1) opened plastic bag of corn on the cob c. one (1) unknown amount of sausage links stored in a plastic bag 4. The following items were located in the kitchen refrigerator and were undated: a. one (1) plastic bag of shredded cheese (unknown amount) b. one (1) open 16 oz. bag of ham lunch meat c. two (2) 1lb opened bags of long grain rice d. one (1) 11 oz. opened bag of hot dog buns e. one (1) plastic bag (unknown amount) of fruit cocktail f. one (1) bag of cut white onions stored in a plastic bag g. one (1) 24 oz opened bag of corn tortillas 5. The following items were located in the kitchen pantry and were undated: a. one (1) unknown amount package of vanilla wafers b. two (2)-12.5 oz of opened bag of potato chips c. one (1) opened bag of brown sugar stored in a plastic bag	A 036	(A036) A list of available snacks is posted in the kitchen where residents can view it. A trash can in the kitchen had a broken lid and was replaced. All food items in the kitchen will be labeled and dated when opened. Leftovers will be discarded after 3 days. Chemicals used for sanitizing will be promptly returned to storage after being used. Hot food will be maintained at 140 degrees and served promptly from the kitchen. The cooks will ensure that food is properly labeled and dated, that leftovers are discarded timely, and that chemicals are stored properly when not in use. The dietary manager will ensure the snack list is posted and that trash cans are in good repair.	06/09/23	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 036	Continued From page 31 6. One (1) one gallon bottle of Clorox was being stored on the kitchen counter; a counter also used to keep food and drinks. B. On [REDACTED]/23 at 11:50 am, during observation of the facility's lunch tray delivered to the Administrator's office revealed: 1. Temperature for the cooked jumbo shrimp temperature was 110 degrees Fahrenheit. 2. Temperature for the cooked carrots was 85 degrees Fahrenheit. 3. Temperature for the cooked rice was 111 degrees Fahrenheit. C. On [REDACTED]/23 at 1:32 pm, during an interview with the Administrator, she confirmed: 1. The one (1) garbage can in the kitchen did not have a tight-fitting lid. 2. The above items observed in the kitchen freezer, refrigerator, and pantry were not dated. 3. The food temperatures for the facility's hot lunch items, described above, were recorded below 140 degrees Fahrenheit. 4. Snacks were not listed on the daily and monthly menu.	A 036			
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	A 037			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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ALBUQUERQUE, NM 87120**

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A 037	Continued From page 32 provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. 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]	A 037		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 037	Continued From page 33 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 the laundry/cleaning supplies were kept in a secured room, closet, or cabinet. This deficient practice could likely result in the [REDACTED] residents identified on the census provided by the Administrator on [REDACTED] 23, 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 [REDACTED] 23 at 10:32 am, during observation of facility's laundry room revealed, the laundry room was unlocked, and the following chemicals were found unsecured: 1. One (1) 3.15 lb bag of detergent pods 2. Two (2) 67.5 fl oz bottles of laundry detergent 3. One (1) 1 gal bottle of disinfectant laundry and air freshener B. On [REDACTED] 23 at 12:31 pm, during an interview with the House Manager, she confirmed chemicals above were located in the unlocked laundry room.	A 037	(A037) A new keypad lock has been installed on the laundry room door to ensure that it remains locked at all times. The house manager will report any issues with the lock to the administrator for prompt repair.	06/20/23
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	A 038		

Division of Health Improvement

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A 038	Continued From page 34 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 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 C Based on observation and interview, the facility failed to ensure that cleaning supplies/hazardous chemicals were stored in secure areas and were not accessible to the residents. This deficient practice could likely result in the [REDACTED] residents listed on the census list provided by the Administrator on [REDACTED] 23, to be at risk of harm, illness, or injury if the residents were to spill or ingest the hazardous chemicals. The findings are: A. On [REDACTED] 23 at 10:11 am, during observation	A 038		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 038	Continued From page 35 of the facility's unlocked storage room the following chemicals were observed: 1. One (1) 4 oz can of glue bond 2. Two (2) 5.75 oz cans of spray paint 3. One (1) 32 bottle of professional drain treatment 4. Two (2) 14.4 oz cans of lubricant 5. One (1) 12 oz can of protectant enamel 6. One (1) 300 count container of disinfect wipes 7. One (1) 32 oz container of spackling 8. One (1) 120 fl oz can of paint and primer 9. Two (2) 124 oz cans of paint 10. Three (3) 5 gal buckets of paint 11. One (1) 1 quart bottle of brush cleaner 12. One (1) 1.53 gal bottle of laundry detergent 13. Two (2) 1 oz bottles of epoxy 14. Five (5) 10.1 fl oz tubes of siliconized sealant 15. One (1) 5.5 fl oz tube of sealant 16. One (1) 14 oz container of plumber sealing 17. One (1) unlabeled and unspecified sized can of liquid 18. One (1) 1.5 oz container of plant food B. On [REDACTED] 23 at 10:38 am, during observation of the facility's unlocked staff restroom, revealed one (1) 32 oz bottle of glass cleaner stored under the sink. C. On [REDACTED] 23 at 10:41 am, during observation of the facility's unlocked activities hall closet, the following chemicals were noted: 1. One (1) 8 fl oz bottle of glue 2. Four (4) 128 fl oz bottles of paint 3. Thirteen (13) 8 oz bottles of paint 4. Seventeen (17) 4 fl oz bottles of of paint 5. Eight (8) fl oz bottle of glue sealer 6. Ten (10) 2 fl oz bottles of paint D. On [REDACTED] 23 at 10:40 am, during an observation of the facility's kitchen revealed:	A 038	(A038) The fire riser room is accessed through a storage room, which will be kept locked at all times. Cleaning chemicals and activities supplies which may be harmful are now stored in locked areas accessible only to staff. The house manager will ensure through daily rounds that all cleaning supplies or harmful chemicals are stored securely and not accessible by residents.	06/12/23	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 038	Continued From page 36 1. One (1) gallon bottle of bleach was unsecured on the kitchen counter. 2. One (1) gallon bottle of multipurpose cleaner was in an unlocked kitchen cabinet. E. On [REDACTED] 23 at 12:38 pm, during an interview with the House Manager, she confirmed that the chemicals located in the storage room and staff restroom were unsecured and accessible to residents. F. On [REDACTED] 23 at 1:35 pm, during an interview, the House Manager, she confirmed that the chemicals observed in the kitchen were unsecured and accessible to residents.	A 038			
A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or	A 043			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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NAME OF PROVIDER OR SUPPLIER

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BEEHIVE HOMES OF VOLCANO CLIFFS

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ALBUQUERQUE, NM 87120**

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A 043	Continued From page 37 (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.43 Based on observation and interview, the facility failed to ensure that combustible items in the mechanical/electric room were not stored in an area with gas fueled heaters and hot water heaters. This deficient practice could likely result in the [REDACTED] residents listed on the census, provided by the House Manager on [REDACTED] 23, to be at risk of harm, injury, or death if a fire were to occur. The Findings are: A. On [REDACTED] 23 at 10:06 am, during observation of the mechanical/electric room, where the gas fuel fired hot water heaters were located, the following combustibles were observed:	A 043	(A043) The items listed have been removed from the fire riser room. The facility administrator will ensure that combustible items are not kept in the fire riser room.	06/17/23

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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NAME OF PROVIDER OR SUPPLIER

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BEEHIVE HOMES OF VOLCANO CLIFFS

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ALBUQUERQUE, NM 87120**

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A 043	Continued From page 38 1. Six (6) twin mattresses 2. one (1) platform frame 3. one (1) wire spring 4. one (1) recliner 5. a wooden chair 6. a twin head board 7. a wooden round table 8. Six (6) rows of unidentified filled cardboard boxes 9. a plastic floor fan B. On [REDACTED]/23 at 1:32 pm, during an interview, the House Manager confirmed that the combustible items were being stored in the same room as the gas fuel fired hot water heaters.	A 043		
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. (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	A 068		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEEHIVE HOMES OF VOLCANO CLIFFS

**6230 MONTANO RD NW
ALBUQUERQUE, NM 87120**

(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 39 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 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	A 068		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 068	Continued From page 40 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 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	A 068		

Division of Health Improvement

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NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF VOLCANO CLIFFS			STREET ADDRESS, CITY, STATE, ZIP CODE 6230 MONTANO RD NW ALBUQUERQUE, NM 87120		
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A 068	Continued From page 41 (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 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 pursuant to 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)	A 068			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 068	Continued From page 42 shall be updated with significant changes in the 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 the resident 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 to schedule 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 or formal depending on the nature of the issue. (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 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	A 068		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 068	Continued From page 43 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 B (1) Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS) had completed a minimum of six (6) hours per year of palliative/hospice care training. This deficient practice could likely result in the [REDACTED] residents identified as receiving hospice care services on the resident census list provided by the Administrator on [REDACTED]/23, to be at risk of harm or injury if DCS have not received training on the proper methods of providing hospice care and services. The findings are: A. Record review of staff training files for DCS #2 (date of hire [REDACTED]21), revealed no documentation of receiving a minimum of six (6) hours per year of palliative/hospice care training since 2021. B. On [REDACTED]/23 at 1:37 pm, during an interview with the Administrator, she confirmed that the facility could not show documentation that DCS #2 received the required 6 hours of palliative/hospice care training annually.	A 068	(A068) The facility will provide a minimum of six (6) hours of palliative/hospice care training per year in addition to basic staff education requirements. All training completed will be documented and maintained by the house manager, who will also monitor each employee for completion of the training. Current staff will complete a pro-rated number of hospice training hours to be current as of 7/31/23.	07/31/23

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services	A 069		

Division of Health Improvement

STATE FORM

6899

GF711

If continuation sheet 45 of 50

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 069	Continued From page 45 and care requirements are relevant to the resident and disease process. (1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider. C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) 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;	A 069			

Division of Health Improvement

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A 069	Continued From page 46 (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. E. Assessments and reevaluations. (1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission. (a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident 's stay in the assisted living facility	A 069			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 069	Continued From page 47 memory care unit is still appropriate. F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record: (1) the physician ' s diagnosis for admission to a secure environment or a memory care unit; (2) the pre-admission assessment; and (3) the re-evaluation(s). G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has	A 069		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 069	Continued From page 48 been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 C Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS) completed a minimum of twelve (12) hours per year of training related to Dementia or Alzheimer's (memory loss) disease. This deficient practice could likely result in the	A 069		

Division of Health Improvement

STATE FORM

6899

GFW711

If continuation sheet 49 of 50

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/09/2023
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A 069	Continued From page 49 [REDACTED] residents identified as having a [REDACTED] diagnosis on the resident census list provided by the Administrator on [REDACTED] 23, to be at risk of harm or injury, if DCS have not received training on the proper methods of providing dementia care and services. The findings are: A. Record review of staff training files for DCS #2 (date of hire [REDACTED]/21), revealed no documentation of receiving a minimum of twelve (12) hours of required training annually related to Dementia/Alzheimer's disease since 2021. B. On [REDACTED] 23 at 1:37 pm, during an interview with the Administrator, he confirmed that there was no documentation showing that DCS #2 received the required 12 hours of Dementia/Alzheimer's related training annually since 2021.	A 069	(A069) The facility does not provide a memory care unit, although it does provide care for several residents with diagnoses of dementia. The facility will provide staff training to comply with the New Mexico Long Term Care Facility Dementia Training act, at a minimum. The facility will provide additional training to meet specific resident needs as those are identified. The house manager will ensure that all such training is provided and documented.		07/31/23