BeeHive® HOMES of Four Hills

Attention: DOH Review office
Fax: (505) 476-9048

From: Beehive Homes of Four Hills Bldg 102
House Phone: 505-299-1203
Morgan's Cell: 505-697-9339 (text/call)
Fax: 505-332-8071

Regarding:

Plan of correction submission
License # 3004

Morgan Leach

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3004	A. BUILDING: 102 B. WING n/a	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF FOUR HILLS 2	13450 WENONAH SE ALBUQUERQUE, NM 87123

(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 complaint survey completed on 11/24/20 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake #45579 was substantiated with deficiencies cited.	A 000		
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;	A 026		

Morgan Leach 04/17/2021 Administrator

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A 026	Continued From page 1 (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.26 A (1) Based on record review and interview the facility failed to ensure for 2 (R #s 1 & 2) of 2 (R #s 1 & 2) residents whose Individual Service Plans (ISPs) were reviewed for compliance, that all the residents conditions/needs were addressed in the ISP. This deficient practice could likely result in harm, injury, and or death, if Direct Care Staff (DCS) are not aware of all conditions/needs and do not know what care and services they need to provide. The findings are: Findings related to R #1 A. Record review of the facility's Hospice and Home Health Verbal Conference form dated 03/16/20 revealed that upon admission to the facility R #1 has a [redacted] B. Record review of R #1's ISP dated 03/16/20 revealed no documentation of a wound on the residents [redacted] would be provided by the hospice agency.	A 026	Response to A 026: All resident IPS's have been reviewed for accuracy to ensure that each reflects the current needs/conditions of each resident. The facility Administrator will regularly review all Individual Service Plans (ISPs) to ensure that all residents' conditions and needs are addressed. All ISPs will be updated when a change in condition occurs, or every 6 months, whichever comes first.	04/17/2021

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A 026	Continued From page 2 C. Record review of R #1's Resident Evaluation dated 03/16/20 revealed: [redacted] D. On 10/29/20 at 9:54 am, during an interview with the Administrator, she confirmed that R #1's ISP had no documentation that there was a [redacted] on the resident's [redacted] and that hospice would be providing [redacted] In addition the Administrator confirmed that R #1 was admitted to the facility on [redacted] 20 with a [redacted] Findings for R #2. E. Record review of R #2's hospice visit notes revealed [redacted] was monitored/treated for [redacted] on the following days: [redacted]	A 026		

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A 026	Continued From page 3 [redacted] F. Record review of R #2's Face Sheet (date unknown) revealed a diagnosis of [redacted] G. Record review of R #2's ISP dated 06/22/20 revealed no documentation that R #2 had [redacted] H. On 11/18/20 at 9:15 am, during an interview with the Administrator, she confirmed that R #2 does have a diagnosis of [redacted] caused by a medical condition that she takes medication for and can appear anywhere on [redacted] Hospice continues to do weekly visits and provides [redacted] when needed for the [redacted] when they occur.	A 026		
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	A 033		

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A 033	Continued From page 4 responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary 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;	A 033		

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A 033	Continued From page 5 (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the 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	A 033		

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A 033	Continued From page 6 treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (5) (11) (a) Based on record review and interview the facility failed to ensure for 1 (R #1) of 2 (R #s 1 &2) residents who were identified as having [redacted] This deficient practice did result in the resident	A 033	In response to A 003 The facility staff did suspect infection of R#1 [redacted] In the future, the Administrator of BeeHive Homes of Four Hills will respond by getting a second opinion of suspected worsening conditions by seeking emergency medical attention at the facility, or by sending the resident out to receive medical attention, even if it contradicts the coordinated care team/hospice staff assessments and opinions.	04/16/2021

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A 033	Continued From page 7 being hospitalized [redacted] The findings are: A. Record review of Department of Health (DOH) Complaint Intake #45579 dated 06/29/20 revealed that the complainant reported that R #1's [redacted] In addition the complainant reported that R #1 was at risk of [redacted] B. Record review of R #1's hospital records dated 06/24/20 to 07/03/20 revealed the following: 1. Resident presented to the Emergency Room (ER) with a [redacted] 2. The dressing had completely adhered to the wound bed and was saturated with normal [redacted] 3. When the dressing was removed it was [redacted] 4. The wound bed was difficult to visualize [redacted]	A 033		

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A 033	Continued From page 8 [redacted] 5. Resident was treated with antibiotics for the infection [redacted] C. Record review of R #1's Facility Admission/Discharge Agreement dated [redacted]/20 (date of admission) revealed that the Resident Risk Agreement Contract stated that R #1 had a [redacted] D. Record Review of R #1's Admission Evaluation dated [redacted]/20 revealed: [redacted] E. Record review of R #1's Individual Service Plan (ISP) dated 03/16/20 revealed no documentation that [redacted] F. Record review of the Hospice Admission Meeting form dated 03/16/20 revealed R #1 had a [redacted] G. Record review of R #1's facility's 1-hour Resident In-Service and Daily Red Flag forms	A 033		

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A 033	Continued From page 9 dated 05/11/20 to 06/24/20 relevant to complaint revealed the following: [redacted] H. Record review of the Hospice Clinical Note dated 05/11/20 revealed that: [redacted] I. Record review of of the facility Visitor Log dated 03/11/20 through 06/26/20 revealed that the on 05/14/20 there was a change in hospice nurses for R #1. J. Record review of Resident Temp-Logs revealed the resident had a temp of 111.0. on 06/24/20 at 10:37 pm. Her temperatures on 06/24/20 at 12:14 am was 94, at 6:12 am was 97.1, at 9:14 am was 98, and at 12:48 pm was 98. K. Record review of Physician Orders dated	A 033		

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A 033	Continued From page 10 [redacted] L. Record review of R #1's physician's order dated [redacted]20, revealed that [redacted] M. Record review of R #1's MAR (Medication Assistance Record) dated 06/01/20 to 06/30/20 revealed that the [redacted] was started on [redacted]20 and needed to be administered by a nurse. N. Record Review of Outside (Hospice) Service Notes dated 03/26/21 through 06/22/20 revealed the following: [redacted]	A 033		

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A 033	Continued From page 11 [redacted]	A 033		

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A 033	Continued From page 12 O. On 10/29/20 at 9:54 am, during an interview with the Administrator, she confirmed that R #1 moved into the facility on 03/16/20 in the evening from a local Nursing Home by non-emergency ambulance. Her son/POA (Power of Attorney) was deemed unable to make decisions and there was no guardian in place upon admission. The Administrator stated that R #1 arrived with a [redacted] that according to hospice was approximately the [redacted] nurse cleaned the [redacted] When admitted the resident was not able to bear weight and required total assistance with Activities of Daily Living (ADLs). She reported that over time the [redacted] P. Record review of Application of Guardianship filed by Hospice was received by the courts on 05/08/20 Q. On 11/04/20 at 12:00 pm, during an interview with the Former House Manager (FHM), she stated that the hospice wound care nurse was coming in weekly to see R #1 and do [redacted] the facility staff did call hospice a couple of times with concerns about [redacted] being infected. The FHM stated that after the change of hospice nurses occurred (05/14/20), staff saw the wound for the 1st time and became concerned that it was infected, and there was a [redacted] Staff were told by nurses, that the [redacted] was not infected. On one occasion, the staff took a picture of the [redacted] 05/27/20) and sent it to hospice, the nurse got an order for pills to crush and put in the [redacted] (dated unknown), which was done only by the hospice nurses. The FHM said that she left the facility before R #1 went to the hospital.	A 033		

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A 033	Continued From page 13 R. On 11/18/20 at 10:20 am, during an interview with Temporary Guardian (TG #1) she stated that [redacted] complaint with the facility was that they should have sent R #1 out to ER when they saw that the [redacted] also stated that if the facility had sent the picture taken on 05/27/20 when requested on 06/22/20 and not waited until 06/24/20, then R #1 would have received emergency medical care 2 days earlier and may not of had to have [redacted] S. On 11/18/20 at 3:34 pm, during at interview with Temporary Guardian #2 (TG #2), [redacted] stated that [redacted] was not assigned R #1's case until 06/22/20 and was not able to visit the resident due to Covid-19 (a highly infectious fast spreading virus) restrictions. TG #2 stated that [redacted] spoke to the Administrator on 06/22/20 and requested the Administrator take a picture of the [redacted] the next time hospice provided [redacted] and send it to [redacted] TG #2 stated that [redacted] did not receive the picture of R #1's [redacted] until 06/24/20 and believed the picture was taken on 06/24/20. [redacted] later learned that the picture had been taken the month before on 05/27/20. When [redacted] saw the picture of R #1's [redacted] called the Administrator and instructed her to call 911 and have R #1 taken to the Emergency Room (ER) immediately. T. On 11/23//20 at 2:10 pm, during an interview, the Administrator stated that: 1. She and other Direct Care Staff (DCS) were in constant contact with the hospice agency, who did weekly visits to the facility to provide [redacted] to R #1's [redacted]	A 033		

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A 033	Continued From page 14 2. She saw the [redacted] on 05/11/20 and on 05/27/20. 3. The picture of the [redacted] was taken on 05/27/20 and showed a [redacted] 4. TG #2 did contact [redacted] on 06/22/20 and requested that a picture of the R #1's [redacted] 5. She did not see or take a picture of R #1's [redacted] on 06/22/20 when hospice nurse last did a [redacted] visit. 6. The picture sent to TG #2 on 06/24/20 was the picture taken on 05/27/20. 7. The facility staff did expressed concerns about R #1's [redacted] to the hospice nurses after they saw the [redacted] but never received instructions to seek additional medical care. There was no guardian/surrogate decision maker in place to make that decision, so the Administrator did not think the facility could make that decision to send R #1 to the hospital.	A 033		