STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2288	A. BUILDING: _____ B. WING _____	05/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO	200 SHERIFFS POSE ROAD BERNALILLO, NM 87004

(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 An Initial survey was completed on 05/13/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the survey.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant	A 016		

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A 016	Continued From page 1 training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 016		

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A 016	Continued From page 2 7.2.8.16 B (3) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for	A 016		

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A 016	Continued From page 3 employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other	A 016		

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A 016	Continued From page 4 governmental agency. [7.1.12.8 NMAC - N, 01/01/2006]	A 016		

Based on record review and interview, the facility failed to ensure that inquiries were submitted for requirements of the Employee Abuse Registry (EAR) within 10-days prior to hire for 3 of 3 Staff (S #s 1, 3, and cook) whose Final Registry Reports were reviewed for compliance. This deficient practice has the potential for all residents to be at risk of being abused/neglected/exploited by allowing a person who has been placed on the registry for abuse, neglect, and/or exploitation of a vulnerable adult to have access to them. The findings are:

A. Record review of S #1's Final Registry Report revealed that the EAR inquiry was not made until 02/02/16, 6-days after her hire date of 01/28/16.

B. Record review of S #3's Final Registry Report revealed that the EAR inquiry was not made until 02/09/16, over 2-months after her hire date of 12/08/15.

C. Record review of the Cook's Final Registry Report revealed that the EAR inquiry was not made until 12/01/15, 23-days after his hire date of 11/09/15.

D. On 05/11/16 at 2:40 pm, during interview with the Administrator and House Manager, They confirmed that the EAR inquiries for S #s 1, 3, and the Cook were not made prior to hire as required.

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A 019	Continued From page 5	A 019		
A 019	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises. (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days.	A 019		

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A 019	Continued From page 6 [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Immediate Jeopardy On 05/13/16 at 9:45 am, an Immediate Jeopardy was called when the 12 (R #s 1-12) residents and staff were found to be in extreme danger of harm or death due the facility failing to have enough staff (minimum of 2-staff members) on duty at all times to safely evacuate in case of fire or other emergency. Record review, observations, and interviews revealed that R #12 requires the assistance of at least 2-staff members to lift/transfer him from his bed to the floor, then be evacuated from the building on his bedsheet, potentially causing him pain or injury. Observation of a fire drill, including evacuation of residents conducted on 05/12/16 at 4:44 pm, revealed that even with 2-staff members they would not be able to evacuate R #12 without a high potential risk of causing him pain or harm and would require Emergency Medical Assistance to get him back in bed, therefore he was not evacuated during the drill. Observation of R #12's room revealed that his hospital bed would not fit through either his bedroom or exit doors of the facility, preventing him from being evacuated in his bed. Record review of the weekly staffing schedule dated 05/08/16 to 05/14/16 revealed that there are times when only 1 staff member is on duty,	A 019		

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A 019	Continued From page 7 especially on the graveyard shift. Therefore the facility is not scheduling enough staff (minimum of 2-staff members) at all times to meet the transfer/evacuation needs of R #12 and still be able to safely evacuate the other 11 (R #1-11) residents. On 05/13/16 at 9:55 am, during interview with the Administrator and House Manager, they confirmed that there is not enough staff on duty at all times, especially the graveyard shift to safely transfer/evacuate R#12 and the other 11 (R #s 1-11) residents at the same time. On 05/13/16 at 11:25 am, a plan of removal for the Immediate Jeopardy was received from the House Manager and accepted. The plan of removal states: 1. The facility will ensure that 2 staff members will be on duty at all times due to the level of care needed for the current residents residing at the facility. 2. As long as the there are residents that require that level of care the House Manager will staff the facility appropriately to ensure the safety and welfare of all residents at all times. 7.8.2.19 A Based on record review, observation, and interview the facility failed to ensure that there was a minimum of 2 staff members on duty at all times to meet the transfer/evacuation needs for 1 (R #12) of 1 (R #12) resident identified by the House Manager on 05/12/16 as requiring the assistance of 2-staff members to evacuate the facility in case of fire or other emergency. If there is not enough staff on duty at all times to safely transfer/evacuate all residents from the building	A 019		

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A 019	Continued From page 8 then they are at an increased risk of harm or death if a fire or other emergency that requires evacuation should occur. The findings are: A. Record review of R #12's Evaluation (not dated) revealed that he needs the support of 2 staff to walk. B. Record review of R #12's Service Plan dated 03/23/16 revealed that he is not ambulatory (able to stand, walk, or transfer). C. Record review of R #12's Fire Evacuation Score Evaluation, completed by the House Manager on 05/13/16 revealed that R #12 needs full assistance from 2 staff to evacuate the facility. D. On 05/12/16 at 4:00 pm, during interview with the House Manager, she stated that at least 2-staff members would have to lift R #12 (approximate weight is 300 pounds) off of his bed with the sheet and pull him out of the building to safety in case of fire or other emergency that requires evacuation. E. On 05/12/16 at 4:44 pm, during observation of a fire drill that included evacuation of the residents, it was observed that even 2-staff members would not be able to evacuate R #12 without a potential risk of causing him pain or harm. F. On 05/12/16 at 4:50 pm, during observation of R #12's room, it was observed that he could not be evacuated from his room or the building in his bariatric (extra wide) hospital bed, because it would not fit through the bedroom or exit doors of the facility. G. On 05/12/16 at 5:10 pm, during interview with	A 019		

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A 019	Continued From page 9 the House Manager, she confirmed that they did not evacuate R #12 during the fire drill due to the potential risk of causing him pain or harm. She stated that if they did evacuate him they would have to call the paramedics to safely get him back into bed. The House Manager also confirmed that R #12 is no longer to get out of bed. H. Record review of the weekly staffing schedule dated 05/08/16 to 05/14/16 revealed that there are times when only 1-staff member is on duty, especially on the graveyard shift when only 1-staff member is scheduled. I. On 05/13/16 at 8:20 am, during interview with R #12, he confirmed that he is unable to stand and/or assist staff if he had to be transferred/evacuated from the building in case of fire or other emergency. J. On 05/13/16 at 8:30 am, during interview with the House Manager, She confirmed that there are times when only 1 staff member is on duty, especially on the graveyard shift when only 1 staff member is scheduled. K. On 05/13/16 at 9:55 am, during interview with the Administrator and House Manager, they confirmed that there is not enough staff on duty at all times, especially the graveyard shift to safely transfer/evacuate R#12 and the other 11 (R #s 1-11) residents at the same time.	A 019		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a	A 020		

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A 020	Continued From page 10 designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved	A 020		

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A 020	Continued From page 11 sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical	A 020		

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A 020	Continued From page 12 condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES);	A 020		

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A 020	Continued From page 13 (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) (12) (a), C Based on record review and interview the facility failed to ensure: 1. The Admission/Discharge Agreements are accurate and complete. 2. An Admission/Retention team meeting is convened prior to admitting/retaining residents on hospice and/or who require a higher level of care	A 020		

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	2288	A. BUILDING: _____ B. WING _____	05/13/2016

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A 020	Continued From page 14 than the facility would normally provide to determine if the facility is an appropriate placement, for 6 (R #s 1, 2, 5, 10, 11 and 12) of 12 (R #s 1-12) residents reviewed for admission/discharge agreements. This deficient practice has the potential for the residents to be at risk of: 1. Being misinformed regarding when a facility can/cannot discharge a resident and the amount of notice the facility is required to give. 2. Being charged for new/changed care services without the appropriate 30-day notice. 3. Needing a higher level of care and services than staff can provide if a team meeting is not held prior to admitting or retaining a resident on hospice or requiring a higher level of care then facility would normally provide. Findings related to Admission/Discharge Agreements: A. Record review of R #1's Admission/Discharge Agreement dated 04/05/16 revealed that: 1. The agreement does not state it may be terminated "if" an appropriate placement is found for the resident. 2. The agreement incorrectly lists the following emergency situations that the facility can terminate the agreement: a. If the resident fails to pay for a stay at the facility. b. If the facility ceases to operate and is no longer able to provide services to residents. c. Due to sanctions and remedies imposed by the department (assuming Department of Health). 3. The agreement incorrectly states: a. "If non-payment of rent occurs, then an immediate or emergency transfer would be necessary without 15-days written notice."	A 020		

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A 020	Continued From page 15 b. A notice will be served at least 30-days before the facility executes the transfer or discharge, except in the event of "Resident fails to pay for the services provided by the [Name of Facility]." 4. Does not state that the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed. B. Record review of R #2's Admission/Discharge Agreement dated 03/18/16 revealed that: 1. The agreement does not state it may be terminated "if" an appropriate placement is found for the resident. 2. The agreement incorrectly lists the following emergency situations that the facility can terminate the agreement: a. If the resident fails to pay for a stay at the facility. b. If the facility ceases to operate and is no longer able to provide services to residents. c. Due to sanctions and remedies imposed by the department (assuming Department of Health). 3. The agreement incorrectly states: a. "If non-payment of rent occurs, then an immediate or emergency transfer would be necessary without 15-days written notice." b. A notice will be served at least 30-days before the facility executes the transfer or discharge, except in the event of "Resident fails to pay for the services provided by the [Name of Facility]." 4. Does not state that the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission	A 020		

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A 020	Continued From page 16 agreement must be executed whenever services, costs or other material terms are changed. C. Record review of R #5's Admission/Discharge Agreement dated 01/18/16 revealed that: 1. The agreement does not state it may be terminated "if" an appropriate placement is found for the resident. 2. The agreement incorrectly lists the following emergency situations that the facility can terminate the agreement: a. If the resident fails to pay for a stay at the facility. b. If the facility ceases to operate and is no longer able to provide services to residents. c. Due to sanctions and remedies imposed by the department (assuming Department of Health). 3. The agreement incorrectly states: a. "If non-payment of rent occurs, then an immediate or emergency transfer would be necessary without 15-days written notice." b. A notice will be served at least 30-days before the facility executes the transfer or discharge, except in the event of "Resident fails to pay for the services provided by the [Name of Facility]." 4. Does not state that the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed. D. Record review of R #10's Admission/Discharge Agreement dated 01/23/15 revealed that: 1. The agreement does not state it may be terminated "if" an appropriate placement is found for the resident.	A 020		

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A 020	Continued From page 17 2. The agreement incorrectly lists the following emergency situations that the facility can terminate the agreement: a. If the resident fails to pay for a stay at the facility. b. If the facility ceases to operate and is no longer able to provide services to residents. c. Due to sanctions and remedies imposed by the department (assuming Department of Health). 3. The agreement incorrectly states: a. "If non-payment of rent occurs, then an immediate or emergency transfer would be necessary without 15-days written notice." b. A notice will be served at least 30-days before the facility executes the transfer or discharge, except in the event of "Resident fails to pay for the services provided by the [Name of Facility]." 4. Does not state that the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed. E. Record review of R #12's Admission/Discharge Agreement dated 03/04/16 revealed that: 1. The agreement does not state it may be terminated "if" an appropriate placement is found for the resident. 2. The agreement incorrectly lists the following emergency situations that the facility can terminate the agreement: a. If the resident fails to pay for a stay at the facility. b. If the facility ceases to operate and is no longer able to provide services to residents. c. Due to sanctions and remedies	A 020		

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A 020	Continued From page 18 imposed by the department (assuming Department of Health). 3. The agreement incorrectly states: a. "If non-payment of rent occurs, then an immediate or emergency transfer would be necessary without 15-days written notice." b. A notice will be served at least 30-days before the facility executes the transfer or discharge, except in the event of "Resident fails to pay for the services provided by the [Name of Facility]." 4. Does not state that the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed. F. On 05/12/16 at 11:00 am, during interview with the House Manager, she confirmed the incorrect and missing information in the Admission/Discharge agreements for R #s 1, 2, 5, 10, 12. Findings related to team meetings for Hospice residents: G. Record review of R #1's resident file revealed that the Hospice Admission/Retention team meeting was not held until 04/26/16, 19-days after she was admitted to hospice on 04/08/16. H. Record review of R #10's resident file revealed that the Hospice Admission/Retention team meeting was not held until 12/09/15, 15-days after she was admitted to hospice on 11/24/15. I. Record review of R #11's resident file revealed that the Hospice Admission/Retention	A 020		

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A 020	Continued From page 19	A 020		

team meeting was not held until 03/09/16, 9-days after she was admitted to the facility on 02/29/16 with hospice services.

J. Record review of R #12's resident file revealed that the the Hospice Admission/Retention team meeting was not held until 04/05/16, 15-days after he was admitted to hospice on 03/22/16.

K. On 05/12/16 at 10:54 am, during interview with the House Manager, she confirmed that the Hospice Admission/Retention team meetings were not being held prior to admitting or retaining residents on hospice.

Findings related to evaluating resident needs and the affect on other residents/staff:

L. Record review of R #12's Facility/Hospice Care Conference (team meeting) form dated 03/31/16 revealed no documentation of discussion regarding the evaluation of his needs during evacuation and/or how meeting his needs would impact the safety and welfare of other residents/staff.

M. Record review of R #12's Evaluation (not dated) revealed that he needs the support of 2 people to walk.

N. Record review of R #12's Service Plan dated 03/23/16 revealed that he is not ambulatory (stand, walk, or transfer) and is not mobile.

O. On 05/12/16 at 4:00 pm, during interview with the House Manager, she stated that at least 2-staff would have to lift R #12 (approximate weight is 300 pounds) off of his bed with the sheet and evacuate him out of the building to

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A 020	Continued From page 20 safety in case of fire or other emergency. P. On 05/12/16 at 4:44 pm, during observation of a fire drill including evacuation of the residents it was observed that the staff would not be able to evacuate R #12 without the risk of causing him pain or harm. Q. On 05/12/16 at 4:50 pm, during observation, R #12 was observed in a bariatric (extra wide) bed that would not fit through the bedroom or exit doors of the facility. R. On 05/12/16 at 5:10 pm, during interview with the House Manager, she confirmed that they did not evacuate R #12 during the drill due to the potential risk of causing him pain or harm. She stated that if they did evacuate him they would have to call the paramedics to get him safely back into bed. The House Manager also confirmed that R #12 is no longer ambulatory or mobile and does not get out of bed. S. On 05/13/16 at 8:20 am, during interview with R #12, he confirmed that he is unable to stand and/or assist staff if he had to be transferred/evacuated from the building in case of fire or other emergency. T. On 05/13/16 at 9:55 am, during interview with the Administrator and House Manager, that they had not evaluated the safety/evacuation needs of R #12, prior to Admitting/Retaining him with hospice services, requiring a higher level of care than the facility would normally provide, or how R #12's needs would impact the safety and welfare of the other residents/staff. They also confirmed that there is not enough staff on duty at all times, especially the graveyard shift to safely transfer/evacuate R#12 and the other 11 (R #s 1-	A 020		

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A 020	Continued From page 21 11) residents at the same time.	A 020		
A 030	7 NMAC 8.2.30 Handling of Resident Funds HANDLING OF RESIDENT FUNDS: A. Each resident has the right to manage their personal funds in accordance with state or federal laws. B. If the facility agrees, the resident may entrust his or her personal funds to the facility for safekeeping and management. In such cases, the facility shall: (1) have written authorization from the resident or his or her surrogate decision maker; (2) maintain a written record of all financial transactions and arrangements involving the resident's funds and make this written record available upon request, to the resident, his or her surrogate decision maker and the licensing authority; (3) safeguard any and all funds received from the resident in an account separate from all other funds of, or held by, the facility; (4) upon written or verbal request by the resident or his or her surrogate decision maker, return to the resident all or any part of the resident's funds given to the facility for safekeeping and management, including all accrued interest if applicable; and (5) upon the resident's death, will transfer all personal funds held by the facility to the resident ' s estate in accordance with Section 45-3-709 NMSA 1978. C. The facility shall not commingle the resident ' s funds, valuables or property with that of the licensee. Resident ' s funds, valuables or property shall be maintained separate, intact and free from any liability of the licensee, staff and management.	A 030		

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A 030	Continued From page 22 [7.8.2.30 NMAC - Rp, 7.8.2.31 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.30 B (1) (2) Based on record review, observation, and interview the facility failed to ensure that they obtain written consent to handle residents' personal funds and to maintain an accurate accounting of resident funds for 3 (R #s 2, 7 and 11) of 3 (R #s 2, 7 and 11) residents identified by the House Manager as having funds maintained by the facility. If the facility does not obtain consent to manage the residents' funds and does not keep an accurate accounting of their monies then residents could have their monies mismanaged or be exploited. The findings are: A. Record review of R # 11's Admission Agreement (page 19) dated 02/29/16 revealed that the permission section of the agreement allowing the facility to handle her personal funds was not completed (left blank). B. On 05/12/16 at 1:15 pm, during observation of R #s 2, 7 and 11's resident personal funds, no transaction/accounting records were observed. C. On 05/12/16 at 1:20 pm, during interview with the House Manager, she confirmed that the facility does handle/maintain resident personal funds for R #'s 2, 7 and 11, but does not keep any transaction/accounting records. She stated "They just keep each resident' s money in a plastic bag with their name on it." The House Manager also confirmed that the the permission section of the admission agreement allowing the facility to handle R #11's personal funds was not completed (left blank).	A 030		

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A 031	Continued From page 23	A 031		
A 031	7 NMAC 8.2.31 Handling of Emergencies HANDLING OF EMERGENCIES: A. Upon admission, each resident or surrogate decision maker shall designate a primary care practitioner (PCP) to be called in case of a medical necessity. Each resident or representative shall also designate a concerned person to be called in case of an emergency. The facility shall establish a policy to secure medical assistance if the resident's own physician is not available. In the event of an illness or an injury to the resident, the PCP or a physician extender shall be notified by the facility. B. The facility shall have a first aid kit that contains at a minimum, gauze, adhesive tape, antiseptic ointment and bandages for emergencies. The first aid kit shall be kept in a designated, easily accessible place within the facility. C. An easily accessible and functional telephone shall be available in each facility for summoning help in case of an emergency. A pay telephone does not fulfill this requirement. D. A list of emergency numbers including: fire department, police department, ambulance services and poison control shall be posted near each public telephone in the facility. [7.8.2.31 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.31 B, D Based on observation and interview, the facility failed to ensure that:	A 031		

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A 031	Continued From page 24 1. A list of emergency phone numbers (fire, police, ambulance, and poison control, etc) is posted in a conspicuous place and accessible to residents/staff/visitors. 2. A first aid kit is available and easily accessible. If the emergency numbers are not posted in a conspicuous place and/or first aid kit is not available then all 12 residents (R #'s 1-12) identified on the resident census list, provided by the House Manager (HM) on 05/11/16 would be at risk of a delayed response from emergency services and not receive needed first aid/medical treatment. The findings are: A. On 05/12/16 at 9:45 am, during observation, there was no list of emergency phone numbers observed to be posted in a conspicuous location within the facility and accessible to residents/visitors/staff. The House Manager confirmed that there was no list of emergency phone numbers posted in the facility. B. On 05/12/16 at 9:47 am, during an observation, no first aid kit was observed within the facility. The House Manager confirmed that there is not a first aid kit at the facility.	A 031		
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	A 034		

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A 034	Continued From page 25 and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document:	A 034		

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A 034	Continued From page 26 (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and,	A 034		

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A 034	Continued From page 27 when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7) Reference NFPA 99, 1999 Edition Section 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases	A 034		

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A 034	Continued From page 28 shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7]. 6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. 7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)]. Reference NFPA 99, 1999 Edition Section 8-3.1.11.3 (Signs)	A 034		

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A 034	Continued From page 29 Based on observation and interview, the facility failed to ensure that: 1. Oxygen cylinder tanks were stored securely, protected from accidental damage or dislocation. 2. Oxygen cylinder tanks were not stored with combustible materials or in a tightly closed space such as a closet. 3. "Oxygen in Use" signs were posted outside the rooms of residents who use oxygen, for 4 (R #s 9, 10, 11 and 12) of 12 (R #s 1-12) residents observed for oxygen storage. If an oxygen cylinder tank were to fall over damaging the valve, causing it to depressurize, stored with combustible materials or in a tightly closed space such as a closet, and if there are not warning signs informing there is "oxygen" in use then residents are at an increased risk of harm if a fire were to occur. The findings are: A. On 05/11/16 at 1:45 pm, during observation of R #11's room, three (3) unsecured oxygen cylinder tanks were observed to be incorrectly stored in the room and there was no "Oxygen in Use" sign posted outside the room. B. On 05/11/16 at 1:45 pm, during interview with S #6, she confirmed that 3-unsecured oxygen cylinder tanks were incorrectly stored in R #11's room and that there was no "Oxygen in Use" sign posted on the outside of the door. C. On 05/11/16 at 1:55 pm, during observation of R #9's room, four (4)unsecured and two (2) secured oxygen cylinder tanks were observed to be stored in an unventilated closet containing clothes and personal belongings that are combustible. 4-unsecured oxygen cylinder tanks were observed to be incorrectly stored in the room and there was no "Oxygen in Use" sign posted outside of the door.	A 034		

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A 034	Continued From page 30 D. On 05/11/16 at 2:01 pm, during observation of R #10's room, 2-unsecured oxygen cylinder tank were observed to be incorrectly stored in the room. 6-unsecured oxygen cylinder tanks were observed in an unventilated closet with clothing and resident belongings that are combustible and there was no " Oxygen in Use " sign on the outside of the door. E. On 05/11/16 at 2:20 pm, during observation of R #12's room, 4-unsecured oxygen cylinder tanks observed to be stored an unventilated closet with clothing, personal care supplies, and resident belongs that are combustible and there was no " Oxygen in Use " sign posted on the outside of the door. F. On 05/11/16 at 2:30 pm, during interview with the House Manager, she confirmed that the oxygen cylinder tanks were incorrectly stored in resident rooms/closets and that there were no "Oxygen in Use" signs posted outside the room doors of R #'s 9-12.	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the	A 035		

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A 035	Continued From page 31 self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For	A 035		

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A 035	Continued From page 32 residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or	A 035		

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A 035	Continued From page 33 problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with	A 035		

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A 035	Continued From page 34 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.35 E, G (4) (5) (7) (10) (11) (17) Based on record review and interview the facility failed to ensure that: 1. The Medication Administration Records (MARs) were accurate, complete, and include documentation of the results of PRN (as needed) medications. 2. That the facility had medication reference material relating to drug interactions and side effect on the premises for 2 (R #s 1 and 2) of 12 (R #s 1-12) residents reviewed for MAR accuracy. If information on the MAR is not complete and accurate then medication errors resulting in harm or the need for medical treatment may occur. If staff is not documenting the results of PRN medications then residents may not be receiving the desired relief and outcomes. If there is no medication reference material available on the premises, then the staff may misidentify the side effects and drug interactions of medications taken by the residents. The findings are: A. Record review of R #1 and R #2's May 2015 MARs revealed the following missing required information: 1. Diagnosis/reason for the medication. 2. Name of the medication including brand name and generic name.	A 035		

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A 035	Continued From page 35 3. The results/outcome of the PRN medications. B. Record review of R #1's May 2015 MAR revealed there was no documentation of the following: 1. Dosage of the medication (e.g. [for example] 1, 2) for 20 of 23 of her medications. 2. Frequency or how often the medication should be given (e.g. daily, at bedtime) for 20 of 23 of her medications . 3. Route the medication should be given (e.g. mouth, oral, eye) for 4 of her 23 medications. 4. Delivery of the medication (e.g. pills, drops, patch) for 19 of 23 of her medications. C. Record review of R #2's May 2015 MAR revealed there was no documentation of the following: 1. Dosage of the medication (e.g. 1, 2) for any of his 10 medications. 2. Frequency or how often the medication should be given (e.g.daily, at bedtime) for any of his 10 medications. 3. Route the medication should be given (e.g. mouth, oral, eye) for 2 of 10 of his medications. 4. Delivery of the medication (e.g. pills/tablets, drops, patch) for 9 of 10 of his medications. D. On 05/12/16 at 9:10 am, during interview with the House Manager, she confirmed the MAR's for R #s 1 and 2 did not contain all the required information.	A 035		

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A 035	Continued From page 36 E. On 05/13/16, at 9:40 am, during observation, no medication reference material was observed on the premises. F. On 5/13/16, at 9:40 am, during an interview the House Manager, she confirmed that there was no medication reference material in the facility.	A 035		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry 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	A 037		

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A 037	Continued From page 37 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] 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 cleaning supplies are kept in a secured room or closet. The deficient practice has the potential for the 12 (R #s 1-12) residents identified on the resident census list provided by the House Manager on 05/11/16 to be at risk of harm or injury if they were to ingest or spill cleaning supplies on their face or body. The findings are: A. On 05/11/16 at 1:35 pm, during observation of the supply closet the door was observed to be open and accessible to residents with a cleaning	A 037		

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A 037	Continued From page 38 cart filled with the following: 1. 1-spray bottle with blue cleaning substance 2. 1-22oz can of bathroom cleaner 3. 4-24 oz bottles of toilet cleaner 4. 1-24 oz bottle of glass cleaner 5. 1-12 oz can of glade spray 6. 1-15 oz can of bug spray 7. 1-28 oz bottle of all-purpose cleaner 8. 1-12 oz can furniture polish B. On 05/11/16 at 2:49 pm, during interview with the House Manager, she confirmed that the storage room was unlocked and the cleaning supplies were accessible to residents. She stated that she was unaware the room was not being locked when not in use.	A 037		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority.	A 063		

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A 063	Continued From page 39 [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Reference NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition: 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Based on observation and interview, the facility failed to ensure that 2 of 2 (kitchen and outside room 12) portable fire extinguishers inspected for compliance were maintained in accordance with NFPA 10 Standard for Portable Fire Extinguishers. This failed practice may result in the failure of the portable fire extinguishers to operate, in the event of a fire and increases the potential risk of harm or injury to residents and staff if a fire were to occur and the fire extinguishers did not work. The findings are: A. On 05/11/16 at 9:20 am, during observation of the kitchen fire extinguisher, the inspection tag revealed no staff signatures indicating that monthly inspections had not been completed. B. On 05/11/16 at 1:54 pm, during observation of the fire extinguisher (outside room #12) inspection tag revealed no staff signatures	A 063		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2288	A. BUILDING: _____ B. WING _____	05/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO	200 SHERIFFS POSE ROAD BERNALILLO, NM 87004

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A 063	Continued From page 40 indicating that monthly inspections had not been completed. C. On 05/11/16 at 2:04 pm, during interview with the House Manager (HM), she confirmed that staff had not been inspecting any of the facility fire extinguishers monthly, therefore not signing the inspection tags on the fire extinguishers. She stated that she was not aware they had to be inspected each month.	A 063		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2288	A. BUILDING: _____ B. WING _____	05/13/2016

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A 070	Continued From page 41 7.8.2.70 E 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying	A 070		

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A 070	Continued From page 42 information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006]	A 070		

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A 070	Continued From page 43 Based on record review and interview, the facility failed to ensure that inquiries were submitted for requirements of the Employee Abuse Registry (EAR) within 10-days prior to hire for 3 of 3 Staff (S #s 1, 3, and cook) whose employee files were reviewed for compliance. This deficient practice has the potential for all residents to be at risk of abuse/neglect/exploitation by allowing a person who has been placed on the registry for abuse, neglect, and/or exploitation of a vulnerable adult to have access to them. The findings are: A. Record review of S #1's Final Registry Report revealed that the EAR inquiry was not made until 02/02/16, 6-days after her hire date of 01/28/16. B. Record review of S #3's Final Registry Report revealed that the EAR inquiry was not made until 02/09/16, over 2-months after her hire date of 12/08/15. C. Record review of the Cook's Final Registry Report revealed that the EAR inquiry was not made until 12/01/15, 23-days after his hire date of 11/09/15. D. On 05/11/16 at 2:40 pm, during interview with the Administrator and House Manager, they confirmed that the EAR inquiries for S #s 1, 3, and the Cook were not made prior to hire as required by regulation.	A 070		