STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7095	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPL ER	STREET ADDRESS, CITY, STATE, Z P CODE
BEEHIVE HOMES OF FOUR HILLS 4	13450 WENONAH AVE SE SUITE 104 ALBUQUERQUE, NM 87123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROV DER'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 an Initial survey completed on 01/20/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.	A 000		
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 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]	A 032	Effective 02/01/2022, any internal incident reports that may threaten the health, safety or welfare of the resident and staff will be reported to the licensing authority within 24 hours of the incident (or the next business if it is a weekend or holiday). An investigation of each incident will be conducted and submitted to the licensing authority within five business days. All records of the submitted incident reports will be monitored and tracked by the Administrator of the facility.	02/01/2022

(Revised 2/16/2022)

PRINTED: 02/01/2022
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 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 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]	A 032	Effective 02/01/2022, any internal incident reports that may threaten the health, safety or welfare of the resident and staff will be reported to the licensing authority within 24 hours of the incident (or the next business if it is a weekend or holiday). An investigation of each incident will be conducted and submitted to the licensing authority within five business days. All records of the submitted incident reports will be monitored and tracked by the Administrator of the facility.	02/01/2022

Mo Roark original: 02/09/2022
revised: 02/16/2022

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A 032	Continued From page 1	A 032		

This REQUIREMENT is not met as evidenced by:
7.8.2.32 A (1) B

Based on record review and interview, the facility failed to ensure for 1 (R #3) of 4 (R #s 1-4) residents whose incident reports were reviewed for compliance that an incident of unusual occurrence (fall with injury) was:

1. Reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend.

2. Conducted an internal investigation and submitted a follow-up investigation report to the Licensing Authority within 5 business days from the date the incident occurred.

This deficient practice could likely cause residents to be at risk for harm, injury, or death if there is no oversight by the Licensing Authority. The findings are:

A. Record review of R #3's incident report dated 12/21/21 revealed no documentation that the resident' [redacted]

1. Was reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend.

2. That an internal investigation was conducted and a follow-up report was sent to the Licensing Authority within 5-business days from the date of the incident occurred.

B. On 01/18/22 at 8:55 am, during an interview

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A 032	Continued From page 2 with the Administrator. she confirmed that the incident of unusual occurrence for R #3 on 12/21/22 was not reported to the Licensing Authority within 24 hours or the next business day. The Administrator also confirmed that the facility did not conduct an internal investigation, nor did they submit a follow-up investigation report to the Licensing Authority within 5 business days of the date the incident occurred.	A 032		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or	A 035	In accordance with state and federal laws, and in reference to 7 NMAC 8.2.35 section G, sub-section 4 and 5: (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; Effective 02/10/2022, any medication administered by staff, or self-administered by resident shall include the diagnosis along with the brand name and generic name listed in the Medication Administration Record. Previous entries have retroactively been corrected to include the generic and brand name as well as a diagnosis, and any entries going forward will include the required information to prevent risk of harm or injury. This will be trained, monitored and overseen by the Operations Director of the facility to ensure compliance. If the Operations Director is unavailable, the Administrator will provide the needed support.	02/10/2022

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A 035	Continued From page 3 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 poss ble side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has;	A 035		

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A 035	Continued From page 4 (3) the name of the resident's PCP or the prescr ber 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 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 prescr bed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication	A 035		

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A 035	Continued From page 5 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 prescr ber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (4) (5) Based on record review and interview, the facility failed to ensure for 4 (R #s 1-4) of	A 035		

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A 035	Continued From page 6 4 (R #s 1-4) residents that the medications listed on the Medication Administration Record (MAR) included: 1. The diagnosis or reason for medication. 2. Both the brand and generic names of the medications. This deficient practice could likely result in the residents being at risk of harm/injury from medication errors if the medications listed on the MARs do not include: 1. The diagnosis or reason for the medication and the Direct Care Staff (DCS) who assist with medications do not know what the medication is for. 2. Both the brand/generic names and the Direct Care Staff (DCS) who assist with medications do not know what the medication is for. The findings are: Findings related to diagnosis or reason for medication use. A. Record review of R #1's 01/01/22 through 01/18/22 MAR revealed, that it did not include the diagnosis or reason for use [redacted] B. Record review of R #2's 01/01/22 through 01/18/22 MAR revealed, that it did not include the diagnosis or reason for use: [redacted]	A 035		

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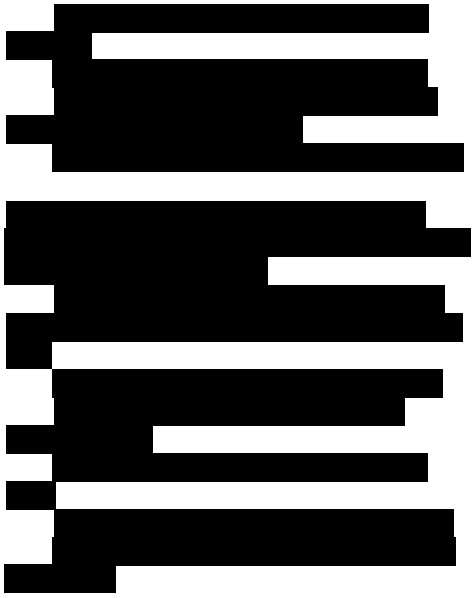
A 035	Continued From page 7	A 035		



D. Record review of R #4's 01/01/22 through 01/18/22 MAR revealed, that it did not include the diagnosis or reason for use:

E. On 01/18/22 at 1:45 pm, during an interview with the Administrator, she confirmed the medications listed above did not include the diagnosis/reason for the medications on R #s 1 through 4's [redacted] /22 through [redacted] /22 MAR.

Findings related to brand/generic medication names.

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A 035	Continued From page 8 F. Record review of R #2's 01/01/22 through 01/18/22 MAR revealed, that it did not include both the brand/generic names for: [redacted] G. Record review of R #3's 01/01/22 through 01/18/22 MAR revealed, that it did not include both the brand/generic names for: [redacted] H. Record review of R #4's 01/01/22 through 01/18/22 MAR revealed, that it did not include both the brand/generic names for: [redacted] I. On 01/18/22 at 1:55 pm, during an interview with the House Manager, she confirmed that the medications listed above did not include both the brand/generic names on R #s 2-4 01/01/22 through 01/18/22 MAR.	A 035		
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;	A 063	Fire extinguishers will be inspected monthly based on the manufacturer recommendation. To maintain compliance, effective 02/01/2022, all fire extinguishers (5 total) will be inspected by facility staff monthly to maintain manufacturer expectations and safety. This will be trained, monitored and overseen by the Operations Director of the facility to ensure compliance. If the Operations Director is unavailable, the Administrator will provide the needed support.	02/01/2022

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A 063	Continued From page 9 (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. [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 the fire extinguishers were being inspected monthly as recommended by the manufacturer. This deficient practice could likely result in the 9 (R #s 1-9) residents identified on the census by the Administrator on 01/18/22, staff members, and other building occupants to be at risk of harm, injury, or death if a fire were to occur and the fire extinguishers do not work. The findings are: A. On 01/18/22 at 12:43 pm, during observation	A 063		

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A 063	Continued From page 10 of the 5 facility fire extinguishers (1 in the kitchen and 4 in the hallways) in the facility, it was observed that they had not been inspected monthly as recommended by the manufacturer. B. On 01/18/22 at 12:45 pm, during an interview with the Administrator, she confirmed that the fire extinguishers in the facility had not been inspected monthly. 7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A	A 063 A 065	Fire drills will be conducted on a monthly basis. Fire safety is reviewed in monthly staff meetings and New Hire Orientation. Effective 02/01/2022, all fire drills (1 per month, alternating every 8 hours - day, evening, night) will be documented and readily available, including the following information: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. This will be trained, monitored and overseen by the Operations Director of the facility to ensure compliance. If the Operations Director is unavailable, the Administrator will provide the needed support.	02/01/2022

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A 065	Continued From page 11 Based on record review and interview, the facility failed to ensure that fire drills were conducted monthly on each eight (8) hour shift (day, evening, night) per quarter. This deficient practice could likely result in the 4 (R #s 1-4) residents identified on the census list, provided by the Administrator on 01/18/22, to be at risk of harm, injury, or death if Direct Care Staff (DCS) do not know how to safely evacuate the residents from the building if a fire were to occur. The findings are: A. Record review of the facility's fire drill record binder revealed, no documentation that they had been conducted in recent months. B. On 01/18/22 at 1:35 pm, during an interview with the Administrator, she confirmed that the facility has no current documentation of conducting any fire drills.	A 065		