STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 07/24/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living Facilities for Adults. Resident Census: [redacted] Complaint Intake NM[redacted] was investigated with deficiencies cited.	8 000		
8 032	8 NMAC 370.14.32 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 8.370.9 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 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 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 8.370.9	8 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 032	Continued From page 1 NMAC; and (3) plans for further actions in response to the incident. [8.370.14.32 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.32 (B) Based on record review and interview, the facility failed to ensure that 4 (R #'s 1-4) of 4 (R #'s 1-4) residents incidents of exploitation were reported to the Licensing Authority within 24 hours or the next business day and that a 5 day follow-up reports were submitted to the Licensing Authority within 5 business days of the incident dates. This deficient practice could likely result in the delay of the implementation of preventative measures to protect the residents from the vulnerability of exploitation. The findings are: A. Record review of the face sheets for residents R #1-4, revealed the following: 1. R #1's face sheets revealed that R #1 was admitted on [redacted], with a diagnosis of [redacted]. R #1 2. Record review of R #2's face sheet revealed R #2 was admitted on [redacted], with a diagnosis of [redacted] 3. Record review of R #3's face sheet	8 032	8 032 Effective immediately, all staff will be retrained on incident reporting procedures, including the requirement to notify the Licensing Authority within 24 hours of discovery and submit the 5-day follow-up report. Any incident involving suspected abuse, neglect, or exploitation will be reported without delay, prior to conducting an internal investigation. The Administrator is responsible for reporting incidents, with oversight by the Compliance Officer. An incident report log will be maintained for all incident reports, including the date/time submitted to the Licensing Authority. The Administrator will review the log weekly, and the Compliance Officer will audit incident reports quarterly to ensure timeliness and compliance with 8.370.9 NMAC.	9-25-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 032	Continued From page 2 revealed R #3 was admitted on [redacted] with a diagnosis of [redacted] 4. Record review of R #4's face sheet revealed R #4 was admitted on [redacted] with a diagnosis of [redacted] R #4's face sheet [redacted] B. Record review of physician's orders for R # 1-4's revealed the following: 1. R #1 was given a prescription by physician order dated [redacted] R #1 was also given a prescription by physician order dated [redacted] 2. R #2 was given a prescription by physician order dated [redacted] R #2 was also given a prescription by physician order dated [redacted] 3. R #3 was given a prescription by physician order dated [redacted] 4. R #4 was given a prescription by physician order dated [redacted]	8 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 032	Continued From page 3 C. Record review of the facilities' incident reports submitted to the State Licensing Authority for the investigation of Exploitation by Misappropriation of Medication dated 04/21/25, revealed during the facility's investigative time period beginning 01/01/25, through 04/18/25, that of the 1,148 [redacted] signed into the facilities' [redacted] for R #'s 1-4, [redacted] D. Record review of the facilities' incident reports submitted to the State Licensing Authority dated 04/21/25, revealed the five (5) day follow-up reports dated 05/01/25 and completed for R #'s 1-4 were not submitted to the Licensing Authority within 5 business days of the incident reporting dates of 04/21/25. E. On 07/17/25 during an interview, Administrator #2 confirmed the 5-day follow-up reports dated 05/01/25 and completed for R #'s 1-4 were not completed and submitted to the Licensing Authority within 5 business days of the incident reporting dates of 04/21/25.	8 032		
8 033	8 NMAC 370.14.33 Resident Rights All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident's understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant	8 033	8 033 Effective immediately, the House Manager identified in the investigation is no longer employed at the facility. All narcotic medications are now secured in the main medication cart and reconciled at every shift change by two staff members. Medications will not be substituted without a physician order. Staff have been retrained on resident rights and the requirement to provide medications as prescribed to ensure pain management needs are met.	4-18-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 4 responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident's medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room;	8 033	8 033 The Administrator and the House Manager are responsible for ensuring compliance with resident rights and proper medication administration. The Administrator will review narcotic counts weekly for the next 60 days. The House Manager and Administrator will review MARs and narcotic logs weekly to confirm accuracy and ensure no substitution of medications occurs. Quarterly audits will be conducted and reviewed with staff in quality assurance meetings.	9-22-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 5 (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a 15 calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within 14 calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance	8 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 6 directives such as living wills and powers of attorney; (m)have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident's surrogate decision maker and outlined in the resident's individual service plan. [8.370.14.33 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.33 D (11) a Based on record review and interview, the facility failed to ensure for 4 (R #'s 1-4) of 4 (R #'s 1-4) residents that: 1. Resident's timed, scheduled medications (dispensed in chronological intervals based on best physical effect) and PRN [pro re nata (as needed)] [redacted] medications were reconciled daily (counted daily to ensure accuracy); 2. The [redacted] medications prescribed by the facility physician were available upon request as prescribed by the physician, and not substituted for another over-the-counter pain medication and; 3. Residents were free from misappropriation of	8 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 7 [redacted]medications by the House Manager (HM) #2. These deficient practices resulted in the residents not receiving [redacted] medications as ordered by their physician to relieve[redacted] and [redacted] which was purchased by their medical plan through their [redacted] The findings are: A. Record review of complaint intake [redacted] revealed on 04/18/25 during a complete [redacted] medication received and signed into the facility for R #'s 1-4 were missing from the locked [redacted] cabinet and the locked medication cart, and not available for administration upon schedule or PRN request for [redacted]. The missing [redacted] tablets totaled approximately 749 tablets for R #'s 1-4. B. Record review of the face sheets for residents R #1-4, revealed the following: 1. R #1's face sheets revealed R #1 was admitted on [redacted], with a diagnosis of [redacted] 2. Record review of R #2's face sheet revealed R #2 was admitted on [redacted]	8 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 8 3. Record review of R #3's face sheet revealed R #3 was admitted on [redacted] 4. Record review of R #4's face sheet revealed R #4 was admitted on [redacted] C. Record review of R # 1-4's physician's orders revealed the following: 1. R #1 was given a prescription by physician order dated [redacted] 2. R #2 was given a prescription by physician order dated [redacted] 3. R #3 was given a prescription by physician order dated 08/24/24, for [redacted] 4. R #4 was given a prescription by physician order dated [redacted]	8 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 9 [redacted]	8 033		

D. Record review of the facility's incident report dated 4/21/25, revealed R #'s 1- 4's [redacted]

1. R #1's [redacted] nvestigative time period of 01/01/25 through 02/21/25, (R #1's end of investigation date is the date [redacted] revealed approximately 141 [redacted] tablets were missing.

2. R #2's [redacted] investigative time period of 01/01/25 through 04/18/25, revealed approximately 268 [redacted] tablets were missing.

3. R #3's [redacted] tablet count investigative time period of 01/01/25 through 04/18/25, revealed approximately 200 [redacted] were missing.

4. R #2's [redacted] count investigative time period of 01/01/25 through 01/27/25, (R #2's end of investigation date [redacted] revealed approximately 140 [redacted] tablets were missing.

E. On 06/24/25 at 10:55 am, during an interview with Direct Care Staff (DCS) #3, they confirmed R #'s 1- 4 stated they were in a great amount of [redacted] medication [redacted]" but were not given the medication because they were not available in the medication cart from 01/01/25 - 04/18/25, and being kept in a separate locked box next to where HM #1 sat and the other staff did not have access to.

F. Record review of the witness statement provided by DCS #5 dated 06/30/25, stated HM #2 asked DCS #5 to substitute an [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 10 [redacted] tablet as the [redacted]g with the same [redacted]S #5 stated the following: 1. During the facility's inve[redacted]od of 01/01[redacted] #1 [redacted] R #1's [redacted] me[redacted] pres[redacted]n order dated [redacted] not [redacted] request. 2. During the facility's inves[redacted]d of [redacted]r request. 3. During the facility's investigative time period of 01/01/25 - 04/18/25, R #3's [redacted]le or request. 4. During the facility's investigative time period of 01/0[redacted]7/25), R [redacted]chedule or request.	8 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 11 G. On 06/30/25 at 10:54 am, during an interview, DCS #5 stated she reviewed the Medication Administration Records (MARs) and found that the [redacted] was signed out as given, by HM #2 who was not on premises at the time the medication was signed out." The MAR stated DCS #5 gave the residents (R #'s 1-4) the medication. HM #2 left at around 2:00 pm, and it was well past that time when DCS #5 was passing (evening) medications. HM #2 had edited the page DCS #5 was entering. DCS #5 stated there was a pop-up notification on the MAR screen in the Blue Step Medication Management Program, as she was making her MAR entries. The popup said the page had been edited by HM #2. The MAR stated HM #2 gave the medication [redacted] before HM #2 left for the day. DCS #5 stated the editing of the MAR screen repeatedly happened. DCS #5 would go in to give the medications to the residents (R #'s 1-4) and wonder how the medication could have already been given. The residents (R #'s 1-4) were scheduled to get the [redacted] in the evening. DCS #5 stated she seen HM #2 had edited the residents (R #'s 1-4) pages in Electronic Medical Records (EMR). H. On 06/30/25 at 2:00 pm, during an interview with [redacted] Nurse [redacted] #1, they stated the following regarding their concerns with R #'s 1-4 pain levels: I believe my patients (R #'s 1-4) were in [redacted]. R #2 would have bouts of [redacted] in the [redacted], for continuous [redacted] needs. This was described as R #2 not responding to the [redacted] measures in place, such as prescribed [redacted] medication. HN #1 stated they knew R #2 was [redacted] because R #2 was [redacted]. The [redacted]g behavior went on for months,	8 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 12 especially while HN #1 was giving weekly [redacted] for R #2's [redacted] R #2 would [redacted] which was unusual for the resident when R #2 was properly medicated as indicated by physician's order, procured by HN #1 for R #2's [redacted] and to aid in R #2's [redacted] during the procedure. HN #1 believed there was no [redacted] medication being given to R #2 for [redacted] prior to the procedure, due to R #2's strong reaction to [redacted]. After HAN #1's discussion with the physician, additional medications were ordered as needed to manage R #2's [redacted] reactions and behaviors. I. On 07/22/25 at 04:11 PM, during an interview, HAN #1 stated that [redacted] HN #1 made the following statements regarding R #'s 1- 4's, medication orders: 1. R #1 R #1 had additional physician orders for [redacted] medication and [redacted] as follows: a. [redacted] b. [redacted]	8 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 13	8 033		

[redacted]

2. R #2
HN #1 stated she knew R #2 was not getting [redacted] medication as well as the other patients (R #'s 1-4) because once HM #2 had gone from the unit, the patients presented as overmedicated and had to be regulated down from the prescribed medications (HN #1 clarified that she had to lower the dosage amounts for R #2, for being too high/strong as R #2 was exhibiting signs of overmedication, such as being overtired. Medication reduction was done to prevent accidental overdosing from the prescribed [redacted]). HN #1 brought these concerns to the [redacted] Nurse Manager [redacted] #2 then addressed R #2's [redacted] response with the [redacted] physician and was able to obtain both [redacted] for R #2 for the following medications:
e. [redacted]
f. [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 14	8 033		

[redacted]

3. R #3
HN #1 stated they (HN #1 and her physician) had to increase the [redacted] to give [redacted] care to R #3, as [redacted] medication was ever available for R #3 upon request. DCS #3 and Administrator #2 explained that HM #2 kept all the [redacted] tablets in a locked [redacted] cabinet that only HM #2 had the key to, therefore the medication was not available for the resident. In addition to the alternate medications for pain, HN #1 also obtained orders for medication for mood stabilization and to reduce behaviors. The additional orders are the following:

[redacted]

4. R #4
HN #1 stated R #4 was in constant [redacted] and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 15	8 033		

suffering #4 was cognitive and able to tell HN #1 h was feeling. R #4 stated to #1 that s still in pain after receiving sche ed pain medications. HN #1 sa 'I d eet she t owing y p order, to control

J. On 06/26/25 at 10:55 am, in a witness statement given by DCS cluding R #4) would ask for the medication for relief f re experiencing. R #4's as not being controlled without he dication.

rd Review of the received from the N nager) on 07/25/25, by Nurse #3, who is no longer a n he facility, and d /03/24 which stated concerns of possible medication diversion. The following rsay and opinion. This is stated so in the email as well. HN #3's concerns began in Se r of 2024. HN #3 stated her suspicion of medication diversion was suspected of be tween the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 16 HM's of facilities #1 and #2, beginning late Spring or early Summer of 2024 as quoted in the email stated as "many months now". This email also described how HM #2 insisting on being the only person to pick up the medications from the pharmacy. HM #2 did not allow the [redacted]s to be delivered by the pharmacy contractor as in normal practice and would only allow herself (HM #2) to pick up the [redacted] from the pharmacy contractor. This action caused suspicion among the HNs. The concerns were relayed to the HNM and the HNM brought those concerns to the FO. L. Record review of another email received from the HNM on 07/25/25, written by HN #3 and dated 09/10/24 stated the following is hearsay and opinion, and that her suspicion that the old [redacted]medication count sheets from 09/03/24 through 09/10/24 had been switched out for new [redacted] count sheets to make the counts match, and that the video footage from the medication room camera was deleted by HM #2 during the facility's investigative time period of 01/01/25 through 04/18/25. M. On 06/23/25 at 2:03 pm, during an interview with Administrator #2, the question was also asked of Administrator #2 in which she made the same statement, confirming that all camera footage of the medication counts and [redacted] medication dispensing by the DCS's had been deleted by HM #2. N. On 07/23/25 at 4:03 pm, during an interview, HNM confirmed concerns regarding [redacted] medications diversion for R #'s 1-4, were brought forth by HN #3 on 09/03/24 which led to HNM contacting the Facility Owner (FO), (specific dates unknown) and began an investigation with	8 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 033	Continued From page 17 an independent pharmacy review in conjunction with the facility, allowing the HNM to be informed of the results. The findings were no medication diversion identified. O. On 06/23/25 at 2:03 pm, during an interview, Administrator #2 confirmed the [redacted] tablets for R #'s 1 - 4 were missing and unaccounted for as outlined in Finding A. The [redacted]e tablets were discovered missing on 04/18/25 during a complete [redacted] review to include the overstock and discharged medications location. Administrator #2 confirmed HM #2 was the only staff member with the key to the locked [redacted] overflow and destruction cabinet. Administrator #2 stated the [redacted] review was prompted due to a tip from an anonymous source who stated HM #2 was diverting [redacted] medications and that the [redacted]' was never available in the medication cart, the [redacted] medication count sheets were unaccounted for, (specific dates unknown) and HM #2 was telling the DCS to substitute prescribed [redacted] for [redacted] P. On 08/18/25 at 2:52 pm, during an interview, the Compliance Officer stated she remembered doing a medication audit sometime around September 2024. She stated she did not look at the overflow [redacted] medications during that audit, because the House Manager (HM) #2 was not there to unlock the overflow [redacted] medication cabinet. She stated she did not document anything regarding those particular audits because there were no findings or errors.	8 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 034	Continued From page 18	8 034	8 034	
8 034	8 NMAC 370.14.34 Custodial Drug Permits A facility with two or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (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	8 034	Effective immediately, narcotic count sheets have been reinstated and are maintained in the narcotic logbook. All controlled substances are counted and signed by two staff at every shift change. Discontinued or expired medications are separated, documented, and secured until destruction by the consulting pharmacist. The House Manager and Administrator are responsible for maintaining proper narcotic documentation with oversight from the Consulting Pharmacist. The Administrator and House Manager will review narcotic logs weekly for accuracy. The Consulting Pharmacist will conduct a full review of controlled substance records quarterly, and findings will be submitted in writing to the Administrator. Discrepancies will be addressed immediately, and results of audits will be reviewed in quarterly quality assurance meetings.	4-20-2025 9-22-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 034	Continued From page 19	8 034		

purchase medications from any pharmacy.
(7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99.
(8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document:
(a) the type and strength of the schedule II through IV drugs;
(b) the date and time staff assisted with self-administration;
(c) the resident's name;
(d) the prescriber's name;
(e) the dose;
(f) the signature of the person assisting with delivery of the medication; and
(g) the balance of medication remaining.
(9) Any remaining medication discontinued by a physician's order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC.
(10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility.
B. Consulting pharmacist: The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance.
(1) Reviews the medication regimen as needed, but at least quarterly/every three months, to determine that all medications and records are accurate and current. All irregularities shall be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 034	Continued From page 20 reported to the administrator of the facility and these irregularities shall be resolved by the administrator within 72 hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 8.370.14 NMAC. [8.370.14.34 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.34 A 8 (g) Based on record review and interview, the facility failed to ensure for 4 (R #1-4) of 4 (R #1-4) residents that [redacted] medication count sheets are maintained in the [redacted] book for staff accountability and verifiable numeric count of [redacted] medications. This deficient practice could likely result in the facility's failure to comply with State and Federal Drug Enforcement Administration (DEA) Regulations regarding the maintenance of scheduled medications (narcotics classification) to remain in pharmaceutical compliance regarding narcotic accountability. The findings are:	8 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 034	Continued From page 21 A. Record review of the facility's [redacted] count sheets and mandatory Direct Care Staff (DCS) end-of-shift [redacted] pill count, completed by facility Administrator #2 and Compliance Officer, revealed approximately 749 [redacted] were missing from 01/01/25 - 04/18/25, from 4 [redacted] residents (R #'s 1-4). B. On 06/18/25 at 08:50 am, during an interview, Administrator #2 stated that during the time period of 01/01/25 - 4/18/25, the [redacted] tablets were not being housed with, nor accounted for in the medication cart. The [redacted] count sheets were also not in the facility's [redacted] count book, where the sheets are maintained. Prescription [redacted] for all residents were kept separately in a locked, overflow and discharged medication cabinet only. Administrator #2 confirmed House Manager #2 (former) was the only staff member with a key for the locked [redacted] overflow and discharged medication cabinet. C. On 06/18/25 at 08:50 am, during an interview with Administrator #2, they revealed as part of the facilities' [redacted] investigation that House Manager #2 had removed the [redacted] sheets from the [redacted] count book causing them to not be available at the mandatory end-of-shift [redacted] pill count by DCS. House Manager #2 also removed all the [redacted]e tablets as well, from the medication cart, causing them to not be available at the mandatory end-of-shift [redacted] pill count by DCS. D. Record review of the facility's Medication Administration Record (MAR), attachment to the Incident Report (IR) dated 04/21/25, the medication count investigation from 01/01/25 -	8 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124

(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
8 034	Continued From page 22 04/18/25 revealed the following for R #'s 1-4: 1. From 01/01/25 until [redacted] R #1, had a total of 256 [redacted] tablets [redacted] signed into the facility. 115 [redacted] tablets were marked as administered, and 141 tablets were missing from the locked [redacted] overflow box and discharged medication cabinet. 2. From 01/01/25 - 04/18/25, R #2 had a total of 524 [redacted]) tablets [redacted] signed into the facility. 238 [redacted]ablets were marked as administered, and 268 tablets were missing from the locked [redacted]s overflow box and discharged medication cabinet. 3. From 01/01/25 - 04/18/25, R #3 had a total of 210 [redacted] tablets [redacted] signed into the facility. 10 [redacted] tablets were marked as administered, and 200 tablets were missing from the locked [redacted]s overflow box and discharged medication cabinet. 4. From 01/01/25 until [redacted] R #4 had a total of 158 [redacted] tablets [redacted] signed into the facility. 18 [redacted] were administered, and 140 tablets were missing from the locked [redacted] overflow box and discharged medication cabinet. E. On 06/18/25 at 10:30 am, during an interview with Administrator #2, it was confirmed that the facility's internal investigation revealed House Manager #2 diverted 749 [redacted] tablets from facility residents R #1 - R #4, dated from 01/01/25 - 04/18/25.	8 034		