Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2268	A. BUILDING: _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF HOBBS	1028 COLLEGE LANE HOBBS, NM 88240

(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 06/09/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the survey.	A 000	According to NMAC 7.8.2.20 Admissions and Discharge: Facility did not meet the requirement based on the homes (2) Program Narrative not stating it is a Memory Care Home, (12) The admission Agreement may be terminated if an appropriate placement is found for the resident and (13) The facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material service provided, a new admission agreement must be executed at this point. This deficient practice has the potential for all 16 current residents and well as potential residents by not being aware the facility is operating as a secured/ memory care unit, an admission agreement being terminated without a place for a resident to transfer to and holds the potential for residents to be charged for new and or changed care services without the appropriate 30- day notice. Administrator will implement a new Resident Admission Agreement to include Memory Care within the Program Narrative, update current Admission Agreement to state that if it is terminated an appropriate placement will be found as well as stating that the facility must provide 30-day written notice of any changes to the residents current Admission Agreement. Current resident Admission agreements will be updated to the new admission agreement. This will be monitored by the Administrator and or Manager upon admission and or change to any care services for all residents.	7-1-2016
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 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	A 020		

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kari Ritzel
TITLE: Administrator
(X6) DATE: 3-1-17

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A 020	Continued From page 1 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 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;	A 020		

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A 020	Continued From page 2 (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 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 020		

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A 020	Continued From page 3 (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); (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]	A 020		

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A 020	Continued From page 4 This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (2) (12) (13) Based on record on review and interview the facility failed to ensure that for 6 (R #s 1-6) of 6 (R #s 1-6) residents' records reviewed for accuracy of admission/discharge agreements, included the following: 1. Information that the facility is operating as a secured/memory care. 2. The statement an "appropriate placement" is found for the resident if the agreement should be terminated. 3. Information that a 30-day notice would be provided prior to any changes in care or costs being implemented. This deficient practice has the potential for the residents to be at risk of not being aware the facility is operating as a secured/memory care unit, admission agreements being terminated without a place for residents to transfer to, and being charged for new/changed care services without the appropriate 30-day notice. The findings are: A. Record review of the resident files for R#s 1-6, revealed that the admissions agreements did not accurately reflect in the program narrative that the facility was being operating as a memory care unit. B. Record review of the resident files for R #s 1-6, revealed that 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 5 C. Record review of the files for R #s 1-6, revealed that the admission agreement does not state that a 30-day written notice is required prior to any changes in services and/or costs. D. On 06/09/16 at 12:30 pm, during interview with the Administrator, she confirmed for R#s 1-6, that the admission agreements were missing the following information: 1. That the facility is operating as a secured/memory care unit. 2. That the agreement may be terminated by the facility "if" an appropriate placement has been found for the resident. 3. That the facility shall provide a 30-day written notice to residents regarding any changes in the cost or the material services provided.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months;	A 021	According to NMAC 7.8.2.21 Resident Records (A) Record Contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Facility did not meet the requirement by having missing or incomplete sections which include: Missing table of contents, outdated assessments, current individual service plans, physical exam report, recent photograph, direct care staff notes, incomplete MAR information, Coordination of care entries from outside agencies. This deficient practice could result in a delay of service or could hold the potential to harm all 16 residents if material is not kept in an organized manner. Administrator has implemented and updated all resident files to include: Table of Contents, Current Assessments, Current Individual Service Plans, Physical Exam reports, Recent	7-1-2016

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A 021	Continued From page 6 (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP;	A 021	Photograph, Direct Care Staff Notes Complete MAR Information Coordination of Care entries as well as being organized according to the table of contents. All resident records will be located within the office readily accessible. Administrator and or Manager will monitor resident records upon admission as well as monthly to ensure compliance with documentation standards.	

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A 021	Continued From page 7 (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction	A 021		

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A 021	Continued From page 8 and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 A (2) (3) (4) (5) (d) (7) (9) (10) B (1) Based on record review and interview, the facility failed to maintain a complete and accurate file/record for 3 (R #s 3, 4 and 5) of 6 (R #s 1-6) residents records reviewed for accuracy. The records had missing or incomplete sections, which included: 1. Missing table of contents. 2. Outdated assessments. 3. Current Individual Service Plans (ISPs) 4. Physical examination report 5. Recent photograph 6. Direct care staff notes 7. Incomplete MARs (Medication Administration Records) information 8. Coordination of care entries from outside agencies 9. Resident records shall be accessible and stored in an organized manner. This deficient practice could result in a delay in care or harm to the residents if documents or important information is missing from the residents' records or the record is not kept in an	A 021		

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A 021	Continued From page 9 organized manner. The findings are: A. Record review of R #s 3, 4 & 5's files revealed that none of the files had a table of contents. B. Record review of R #3's file revealed there was no ISP in the record. C. Record review of R #4's file revealed that the ISP dated 06/07/16 was not reviewed by a nurse. D. Record review of R #5's file revealed that the ISP dated 11/30/15 was not reviewed by a nurse after significant changes in medication dosage and her instructions were written incorrectly on her June, 2016 MARs. R #5's MARS was not updated with the new order of Warfarin 3 mg, take 4.5 mg on Tuesday, Thursday, Saturday and Sunday. R #5 MAR's for June 2016 still has Warfarin, 3 mg tables, take 4 1/2 MG at bed each night. Staff were assisting with the correct dosage, but the MAR's was not updated to reflect the new order. E. Record review of R #s 4 & 5's files revealed they did not have a physicians examination report in their file. F. Record review of R #s 3, 4 & 5's files revealed they did not have a current photograph in their file. G. Record review of R #s 3, 4 & 5's files revealed they did not have any direct care staff notes in their file. H. Record review of R #s 4 & 5's files revealed they did not have notes regarding coordination of care from either a home health or hospice	A 021		

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A 021	Continued From page 10 agency. I. On 06/08/16 at 2:48 pm, during interview with the Administrator, she confirmed that the R #s 3, 4 & 5 files reviewed did not use a table of contents and had missing data in them. She also confirmed that R #5's June 2016 MAR's did not have her current order for Warfarin updated .	A 021		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder;	A 025	According to NMAC 7.8.2.25 Resident Evaluations: A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of service required can be met by the facility. Facility did not meet the requirement by not having resident evaluations completed within 15 days prior to admission in files as well as an updated evaluation every 6 months, including a history, physical examination and physician evaluation revised every 6 months or with a significant change in health status. This deficient act holds the potential for all 16 residents as well as potential residents not to receive appropriate care as well as needed assistance upon admission as well as with significant health changes. Facility will have all new resident's evaluations completed within 15 days prior to admission. Residents evaluations will be reviewed every 6 months or with a change in health status as well as documented on correct evaluation form. This will be monitored by the Administrator and or the Designee prior to and upon admission and or with a significant health change of residents as well as well as every 6 months.	7-1-2016

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A 025	Continued From page 11 (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A, B, C, D, & E. Based on record review and interview, the facility failed to ensure that 3 (R #s 2, 4 and 5) of 16 (R#s 1-16) residents reviewed for timeliness and	A 025		

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A 025	Continued From page 12 accuracy of the resident evaluations were: 1. Completed within 15 days prior to admission. 2. Reviewed at a minimum of every 6 months or when there is a significant change in the resident's health status. 3. Had special medical need services documented that are provided by an outside agency. 4. Had history and physical examination reports. This deficient practice has the potential for the residents to not receive the appropriate care and assistance they need upon admission and as changes in their health status occur due to the evaluations not being completed and reviewed as required. The findings are: A. Record review of R #2's file revealed her evaluation was dated 10/27/15, nearly six weeks past admission date of 09/15/15. B. Record review of R #4's file revealed the evaluation was dated 05/30/16, 15 days past admission date of 05/15/16. The administrator provided a resident census list indicating R #4 was the only resident on hospice, but there was no documentation of any services being provided by a Hospice agency in R #4's file. There was also no Physical Examination from a licensed practical nurse, registered nurse or physician extender. C. 06/07/16 at 9:50 am, during an interview with a nurse, she stated she was a RN from a home health care nurse agency. She stated that she has been providing care for R #4 before the resident moved into the facility. She also stated that she has not seen an ISP for R #4 or any type of document to show coordination of care between agencies.	A 025		

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	2268	A. BUILDING: _____ B. WING _____	06/09/2016

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A 025	Continued From page 13 D. Record review, interview and observation of R #5 's file revealed the following: 1. The medication portion of the evaluation was not updated to reflect change in R #5's Warfarin (blood thinner) dosage instructions, correct dosage would be 3 mg (milligrams) on Monday, Wednesday, Friday and Sunday and the 4 1/2 mg on Tuesday, Thursday and Saturday. On Medication Administration Records (MARs) form, it stated to take both the 3mg and 4 1/2 mg each night. 2. There was no documentation of a Physical Examination from a licensed practical nurse (LPN), registered nurse (RN) or physician extender. E. On 06/07/16 at 3:00 pm, during interview with the Administrator, she confirmed that R #2's evaluation was not completed until 6 weeks past her move in date of 09/15/15 and that R #4's evaluation was not completed until 15 days past admission on 05/15/16. F. On 06/08/16 at 2:45 pm, during interview with the Administrator, she confirmed that R #5's evaluation was not updated, had the wrong Warfarin dosage instructions, there was no documentation of services being provided by a home health agency and no evidence of a physical examination from a LPN, RN or physician extender.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility.	A 026		

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A 026	Continued From page 14 A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010]	A 026	According to NMAC 7.8.2.26 Individual Service Plans(ISP) shall be created and implemented within ten (10) calendar days of admission for each resident residing in the facility. The ISP shall be revised at minimum of every 6 months or upon change in resident's health status. Facility did not ensure that the individual Service Plans were current and placed within the resident's files. The Service Plans were completed within the resident data program however were not printed and available in the residents file. The service plans were also not reviewed by a registered nurse. This deficient practice has the potential to affect all 16 residents by not receiving appropriate care and assistance they need. Facility will have an Individual Service Plan created within 10 days of admission as well as updated a minimum of every 6 months or as a change in health status occurs. Service Plans will be reviewed by Administrator and or Manager as well as the Registered Nurse and placed within the residents file. All current residents ISP's will be updated to show coordination of care with Home Health and or Hospice services where necessary. This will be monitored by the Administrator and or Manager upon admission as well as monthly.	3-10-17

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A 026	Continued From page 15 This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (1) (2) (3) B (1-10) Based on record review and interview, the facility failed to ensure that Individual Service Plans (ISP) were current, accurate, and available for staff members to review for 3 (R #s 3, 4 and 5) of 3 (R #s 3, 4 and 5) residents reviewed for ISP compliance. This deficient practice has the potential for the residents not to receive the appropriate care and assistance they need as changes in their health status occurs. The findings are: A. Record review of R #3's resident file revealed that there was no ISP available for review. B. Record review of R #4's ISP dated 06/07/16 revealed that: 1. It was not reviewed by a nurse at a minimum of every 6 months or when there was a significant change in the residents health status. 2. There was no documentation to show that R #4 was receiving hospice services, coordination of care with a hospice agency and did not accurately reflect the residents current care needs. C. Record review of R #5's ISP dated 11/30/15 revealed that there was no coordination of care with the home health care agency. D. On 06/08/16 at 8:30 am, during interview with the Administrator, she confirmed that R #3's ISP was not in the resident file. E. On 06/08/16 at 8:35 am, during interview with the Administrator, she confirmed that the ISP in R #4's file did not show any coordination of care	A 026		

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A 026	Continued From page 16 with a hospice agency and the file was not reviewed by a nurse. F. On 06/08/16 at 8:37 am, during interview with the Administrator, she confirmed that the ISP in R #5's file did not show any coordination of care with the home health care agency and the ISP had the wrong medication instructions and was not reviewed by a nurse.	A 026		
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,	A 031	According to NMAC 7.8.2.31 (B) A 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. Facility did not meet the requirement as the First Aid kit was not in place. This deficient practice effects all 16 residents and places them at risk of not receiving first aid treatment. Administrator did correct the issue by placing a First Aid Kit in the office at 9:45 am on 6-8-16. This will be monitored by the Administrator and or Manager Monthly to ensure proper supply.	6-08-2016

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A 031	Continued From page 17 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.31 B Based on observation and interview the facility failed to ensure that a first aid kit was available on the premises. This deficient practice has the potential for 16 (R #s 1-16) residents, as identified on the census list provided by the Administrator on 06/07/16, to be at risk of not receiving needed first aid treatment. The findings are: A. On 06/08/16 at 9:30 am, during observation of the facility there was no first aid kit to be found on the premises. B. On 06/08/16 at 9:30 am, during interview with the Administrator, she stated that she does not have a first aid kit at this facility.	A 031		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights	A 033	According to NMAC 7.8.2.33 Resident Rights 11(d) To protect resident rights, the facility residents are free to leave the facility and return without unreasonable restriction. Facility failed to meet this standard by not providing non-memory care residents with the access code to enter and exit. The deficient practice violates all 16 resident's rights to leave the facility or return without unreasonable restrictions. Administrator will create a list of all residents receiving memory care services and those not. Pass Codes will be provided to those appropriate residents without memory care diagnosis and are not an elopement risk. This will be monitored by the Administrator and or Manager upon admission as well as updating list monthly.	7-1-2016

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A 033	Continued From page 18 shall be provided to the most significant 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;	A 033		

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A 033	Continued From page 19 and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s);	A 033		

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A 033	Continued From page 20 (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D 11 (d) Based on record review and interview, the facility failed to ensure that 8 (R #'s 1, 2, 4, 5, 13, 14, 15, and 16) of 16 (R #s 1-16) residents who are not diagnosed by their physicians with Alzheimer's and/or other type of dementia (memory loss) and need placement in a secure facility, are free to leave the facility and return without unreasonable restrictions. This deficient practice violates residents rights to leave the facility or return without unreasonable	A 033		

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A 033	Continued From page 21 restrictions and may lead to isolation and withdrawal from the community. The findings are: A. On 06/09/16 at 8:15 am, during observation, 4 residents, R 's # 2, 5, 13 and 14, that did not have a diagnosis of dementia in their medical records and did not need a secure memory care unit, were waiting for staff to enter a security code so they could exit the facility and sit in the fenced secure patio area. B. On 06/09/16 at 8:30 am, during interview with Administrator, the question was asked how R 's # 2, 5, 13 and 14 were able to access the patio or leave the facility without staff entering code to exit the facility. She explained that all the residents had some form of dementia, and the residents don't mind waiting for staff to open the door.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of	A 034	According to NMAC 7.8.2.34 Custodial Drug Permits (A) and (B) Facility failed to meet the requirement of properly securing Oxygen cylinder tanks, displaying Oxygen is use signs as well as narcotic count sheets not being accurate. The deficient practice has the potential to harm all 16 residents. All Oxygen Tanks were immediately removed from the resident's room and placed in a central location as well as the medical supply companies being contacted to provide the appropriate cages to ensure safe storage. On 6-7-16 Oxygen in use signs were immediately placed on all resident doors that were using oxygen therapy. Extra Oxygen in use signs were ordered to prevent occurrence again. Narcotic count sheets were discussed with the consulting pharmacist and she has adjusted narcotic forms as per the regulations on this day. This will be monitored by the Administrator and or Manager daily.	6-7-2016

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A 034	Continued From page 22 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) 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	A 034		

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A 034	Continued From page 23 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 asneeded, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC.	A 034		

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A 034	Continued From page 24 [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 B 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 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	A 034		

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	2268	A. BUILDING: _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 034	Continued From page 25 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)]. Based on observation, record review, and interview, the facility failed to ensure that: 1. Oxygen cylinder tanks were stored securely, protected from accidental damage or dislocation. 2. "Oxygen in Use" signs were posted outside the rooms of residents who use oxygen, 3. Controlled medication count sheet was complete and accurate.	A 034		

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A 034	Continued From page 26 These deficient practices has the potential for 2 (R #s 5 and 6) of 16 (R #s 1-16) residents to be at risk of harm and/or serious injury if: 1. Oxygen cylinder tanks were to fall over damaging the valve, causing it to depressurize, 2. A fire were to occur and oxygen cylinder tanks were stored in rooms where no warning signs informing there is "oxygen" in use. 3. There is not an accurate count of controlled substances medications then residents may not have their medications and/or medications have not been ordered. The findings are: A. On 06/07/16 at 8:00 am, during observation of R #5's room, two (2) unsecured oxygen cylinder tanks were observed to be stored in the room and there was no "Oxygen in Use" sign posted on the outside of the door. B. On 06/07/16, at 8:15 am, during observation of R #6's room, resident is using oxygen there was no "Oxygen in Use" sign posted on the outside of the door. C. On 06/08/16, at 11:19 pm, during an interview with the administrator, she confirmed that the oxygen cylinder tanks were stored in the resident rooms and that there were no "Oxygen in Use" signs posted outside the room doors of R #s 5 and 6. Findings for controlled medications count: D. Record review of the controlled medications count verification sheets for May 2016 and June 2016, indicated the name of the medication, resident's receiving medication, and the controlled medication count was missing from the	A 034		

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A 034	Continued From page 27 form. E. On 06/08/16 at 8:30 am, during an interview with the Administrator she confirmed the controlled medication count verification sheets for May 2016 and June 2016, were missing the following: name of the medication, resident's receiving medication and the controlled medication count.	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 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	According to NMAC 7.8.2.35 Medication E G (4) (9) (17) M Facility failed to ensure that there was medication reference material relating to drug interactions and side effects on the premise. Facility also failed to ensure the MAR was in compliance with displaying a diagnosis or reason for a medication, the frequency of how often the medication is to be taken or given, results of a PRN medication was not documented accurately as well as appropriate documentation of medication errors. The deficient practice poses a risk to all 16 residents. Facility was using the web based medication reference material and immediately purchased the book 6-8-16 and placed it on top of the medication cart. The missing diagnosis and frequency to be given was corrected immediately on 6-8-16. A PRN effectiveness training will be conducted on 6-13-16 as to where to appropriately document as well as training staff on proper documentation with medication errors. This will be monitored by the Administrator and or Manager monthly, upon incident, or change in medications ordered. Upon review on 2-28-17, staff have continued to not document PRN effectiveness correctly. Manager/ Administrator will conduct PRN Effectiveness in service on 3-6-17. This will be monitored daily by the Administrator and or Manager.	3-6-2017

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A 035	Continued From page 28 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 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 29 (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 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	A 035		

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A 035	Continued From page 30 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 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 E G (4) (9) (17) M Based on record review and interview the facility failed to ensure for 3 (R #s 2, 4-5) of 6 (R #s 1-6) residents who were reviewed for Medication	A 035		

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A 035	Continued From page 31 Administration compliance indicated the following: 1. The diagnosis or reason for the medication. 2. Frequency or how often medication should be given. 3. The Medication Administration Records (MARs) were accurate, complete, and include documentation of the results of PRN (as needed) medications. 4. The facility report all medication errors to the physician and documentation of medications errors and the prescriber's response be kept in the resident's records. 5. That the facility had medication reference material relating to drug interactions and side effects on the premises. 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. 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 are not documenting the results of PRN medications, then residents may not be receiving the desired relief and outcomes. If the staff does not receive instructions from the physician for resident taking the wrong medication the resident may not receive the necessary needed medical treatment. The findings are: A. Record review of R#2 's medical record revealed the incident report 06/07/16 for a medication error was missing the description of medication and the dosage given. The incident was not reported to the resident's physician, and the prescriber's response was not in the resident's records.	A 035		

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A 035	Continued From page 32 B. On 06/08/16 at 8:30 am, during an interview with the Administrator, she confirmed that the incident was not documented correctly and did not state that the physician was contacted. She stated her staff needs to be trained. C. On 06/08/16 at 9:30 am, during observation and interview, no medication reference material was observed on the premises. During interview the Administrator, confirmed that there was no medication reference material in the facility. D. Record review of R #4 and R#5's May 2016 MARs revealed the following missing required information: 1. Diagnosis/reason for the medication. 2. The results/outcome of the PRN medications. E. On 06/08/16 at 2:00 pm, during interview with the Administrator, she acknowledged that she was aware that the MARs for R #4 and #5 did not include the diagnosis/reason for the medication and the results/outcome of the PRN medications. F. Record review of R #4's MARs for May 2016 and June 2016, revealed the following: 1. Warfarin Sodium (an anticoagulant (blood thinner)) 3mg 1 tablet and Warfarin Sodium 3mg 1 1/2 tablets; take both medications every night at bedtime. 2. The doctor's orders are written for Warfarin Sodium 3mg to be taken on Monday, Wednesday, and Friday and Warfarin Sodium 4.5 mg to be taken on Tuesday, Thursday, Saturday, and Sunday. G. On 06/08/16 at 2:30 pm, during interview with the Administrator, she confirmed the medication orders were not written correctly on the MARs	A 035		

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A 035	Continued From page 33 and the Administrator stated "They were not following the doctor's orders."	A 035		
A 044	7 NMAC 8.2.44 Heating, Air-Conditioning and Ventilation HEATING, AIR-CONDITIONING AND VENTILATION: A. Heating, air-conditioning, piping, boilers and ventilation equipment shall be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities shall have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility shall provide a minimum temperature of seventy (70) degrees fahrenheit, measured at three (3) feet above the floor, in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device shall be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances shall be permanently anchored and kept away from flammables such as curtains, bedcovering, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or presents danger from electrical shock. D. Fireplaces and open flame heating shall not be utilized in sleeping rooms. E. Gas fired water heaters shall not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. The facility shall be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural	A 044	According to NMAC 7.8.2.44 Heating, Air-Conditioning and Ventilation: (A) All Facilities shall have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. Facility failed to ensure that the proper personnel maintained, checked or serviced the heating system. This deficient act places all 16 residents at risk of illness or harm if unit malfunctions or quits. Administrator will contact the appropriate personnel to service the heating system and then ensure that it is scheduled yearly. This will be monitored yearly by the Administrator and or Manager.	8-1-2016

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A 044	Continued From page 34 means. G. All openings to the outside air used for ventilation shall be screened for the control of insects and rodents. Screen doors shall be equipped with self-closing devices. H. The facility shall have a system for maintaining the residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7.8.2.44 NMAC - Rp, 7.8.2.45 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.44 A Based on record review and interview, the facility failed to ensure that the gas heating system was checked, tested, and maintained annually by qualified personnel. If the heating system is not tested and inspected annually by qualified personnel, then all 16 (R #1-16) residents identified on the resident census, provided by the Administrator on 06/07/16, are at risk of illness or harm if the furnace quits working during cold weather or has a gas/carbon monoxide leak. The findings are: A. Record review of the annual inspection of the gas heating system, dated June 2014, revealed that this was the last inspection conducted by a licensed plumber or a qualified person. B. On 06/07/16 at 1:30 pm, during interview with the Administrator, she confirmed that she did not have a qualified plumber conduct the annual inspections of the gas heater this past season	A 044		

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A 044	Continued From page 35 (2015).	A 044		
A 060	7 NMAC 8.2.60 Fire Clearance and Inspections FIRE CLEARANCE AND INSPECTIONS: A. Written documentation of a facility's compliance with applicable fire prevention codes shall be obtained from the state fire marshal ' s office or the fire prevention authority with jurisdiction and shall be submitted to the licensing authority prior to the issuance of an initial license. B. The facility shall request an annual fire inspection from the local fire prevention authorities. If the policy of the local fire department does not provide an annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7.8.2.60 NMAC - Rp, 7.8.2.59 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.60 A Based on record review and interview, the facility failed to ensure that an annual fire inspection by the local Authority having jurisdiction had been conducted. This failed practice has the potential for all 16 (R #s 1-16) residents listed on the resident census, provided by the Assistant Manager on 06/07/16, to be in danger of possible harm, injury, or death by fire and/or smoke. The findings are: A. Record review of the annual fire inspection, by	A 060	According to NMAC 7.8.2.60 Fire Clearance and Inspections (A): Written documentation of a facility's compliance with applicable fire prevention codes shall be obtained from the state fire marshal's office or the fire prevention authority with jurisdiction. Facility failed to ensure the local Fire Marshal completed annual fire inspection. This deficient act places all 16 residents at risk. Administrator will contact the local Fire Marshal and request inspection to remain in compliance. This will be monitored by the Administrator and or Manager Annually.	7-31-2016

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A 060	Continued From page 36 the local Fire Marshal dated November 2014, revealed that this was the last inspection of the facility conducted by local authorities. B. On 06/07/16 at 11:45 am, during interview with the Administrator, she confirmed that the facility has not been inspected by the local Fire Marshal since November 2014.	A 060		
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.62 Refer to 7.8.2.62 & National Fire and Protection Association (NFPA) 13 Reference NFPA 13 Section 1-5.1 Maintenance: A sprinkler system installed under this standard shall be properly maintained for efficient service . The owner is responsible for the condition of the sprinkler system and shall use due diligence in keeping the system in good operating condition. Reference: NFPA 13, Sect. 1-6.1 states that a	A 062	According to NMAC 7.8.2.62 Automatic Fire Protection (Sprinkler System) The responsibility for properly maintaining a water-based fire protection system shall be that of the owner(s) of the property. Facility failed to ensure the water-based fire sprinkler system was inspected quarterly by a qualified personnel. This deficient act has the potential to cause harm to all 16 residents. Administrator will contact qualified personnel to inspect the sprinkler system as well as create a quarterly inspection contract to remain in compliance. Administrator contacted qualified personnel and signed a service agreement. This contract did not allow the serviceman to get to the facility until August of 2016. Contract is set to have facility inspected every quarter from here on out. This will be monitored quarterly by the Administrator and or the Manager.	8-31-2016

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	2268	A. BUILDING: _____ B. WING _____	06/09/2016

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BEEHIVE HOMES OF HOBBS	1028 COLLEGE LANE HOBBS, NM 88240

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A 062	Continued From page 37 building, where protected by an automatic sprinkler system installation, shall be provided with sprinklers in all areas. Reference NFPA 25, 1-4.2 The responsibility for properly maintaining a water-based fire protection system shall be that of the owner(s) of the property. By means of periodic inspections, tests, and maintenance, the equipment shall be shown to be in good operating condition, or any defects or impairments shall be revealed. Inspection, testing, and maintenance shall be implemented in accordance with procedures meeting or exceeding those established in this document and in accordance with the manufacturer's instructions. These tasks shall be performed by personnel who have developed competence through training and experience. Reference NFPA 25, 1-4.4 The owner or occupant promptly shall correct or repair deficiencies, damaged parts, or impairments found while performing the inspection, test, and maintenance requirements of this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. Based on observation and interview, the facility failed to ensure that the sprinkler system was inspected quarterly by a qualified person. This deficient practice has the potential to cause harm to all 16 (R #s 1-16) residents identified on the resident census list provided by the Administrator on 06/07/16, if the sprinkler system is not checked quarterly to ensure that it is in working condition should a fire occur. The findings are: A. On 06/07/16 at 9:45 am, during observation,	A 062		

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A 062	Continued From page 38 the fire sprinkler service tag showed the last quarterly service was done on 11/14/14. B. On 06/07/16 at 11:30 am, during interview with the Administrator, she confirmed that the quarterly sprinkler inspection was 18 months past the due date.	A 062		
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. [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 A (3) Based on observation and interview, the facility	A 063	According to NMAC 7.8.2.63 Fire Extinguishers (3): Fire Extinguishers must be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of inspection. Facility failed to ensure that all fire extinguishers were inspected yearly. This deficient act poses a risk to all 16 residents. Administrator will contact qualified personnel to inspect the extinguishers as well as create a contract for annual inspection of extinguishers. Administrator contacted qualified personnel and signed a service agreement. This contract did not allow the serviceman to get to the facility until August of 2016. Contract is set to have facility inspected every quarter from here on out. Monthly inspections of the fire extinguishers will be completed on the appropriate facility form by the manger. This will be monitored monthly and annually by Administrator and or Manager.	8-31-2016

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A 063	Continued From page 39 failed to maintain all 7 portable fire extinguishers in accordance with NFPA 10 Standard for Portable Fire Extinguishers. This has the potential for all 16 (R #s 1-16) residents as identified by the census list provided by the Administrator on 06/07/16, to be at risk of injury or death if the portable fire extinguishers fail to operate, in the event of a fire. The findings are: A. On 06/07/16 at 8:20 am, during observation it was observed that all 7 portable fire extinguishers had not been serviced annually by an authorized contractor and were not inspected monthly by staff. The last service date was June 2014. B. On 06/07/16 at 10:36 am, during an interview with the Administrator, she confirmed that the 7 fire extinguishers had not been serviced annually by an authorized contractor and were not inspected monthly by staff.	A 063		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically	A 068	According to NMAC 7.8.2.68 Hospice C (1): Individual Service Plan (ISP) requirements. Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident's needs outlined in the ISP. Facility failed to ensure that residents receiving hospice services received care coordination between Facility and the Hospice company. The deficient act poses a threat to all residents who choose to receive hospice and or home health services. Facility will complete coordination of care (Care Plan) meetings with all residents receiving hospice/home health services. The meeting will consist of the Hospice Company providing the services, Administrator and or Manager as well as the family. This meeting will also be scheduled upon all new admissions currently receiving hospice services as well as any current residents making the transition into hospice care. This will be monitored and scheduled by the Administrator and or Manager upon admission or at the time of transition of care.	8-1-2016

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A 068	Continued From page 40 directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of	A 068		

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A 068	Continued From page 41 palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals:	A 068		

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A 068	Continued From page 42 (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident	A 068		

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A 068	Continued From page 43 ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP;	A 068		

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A 068	Continued From page 44 (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.68 C (1) Based on record review and interview the facility failed to ensure that there is a care coordination between the facility and the hospice providers for 1 (R #4) of 1 (R #4) resident receiving hospice services. This deficient practice has the potential to negatively effect the health and welfare of residents who have elected to receive the hospice services option by not ensuring the there is coordination of care between the facility and the hospice agency. The findings are: A. Record review of R #4's, Individual Service Plan (ISP) revealed no documentation of the care/services to be provided by the hospice agency. B. On 06/08/16 at 2:45 pm, during an interview with the Administrator, she confirmed there was no documentation of care coordination with the hospice agency in R #4's ISP.	A 068		