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Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4026	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	180 SHERIFFS POSSE RD BERNALILLO, NM 87004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during an initial survey completed on 03/27/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.	A 000		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned,	A 022	NM Department of Health AUG 20 2018 Division of Health Improvement	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 8/17/2018

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A 022	Continued From page 1 including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies: (a) an emergency that affects just the facility; and (b) a region/area wide emergency; (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC); (12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and (13) vaccination records for pets in the facility. B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC;	A 022		

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A 022	Continued From page 2 (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse,	A 022		

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A 022	Continued From page 3 neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010]	A 022		

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A 022	Continued From page 4 This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (1) (10) (a) Based on record review and interview, the facility failed to have a fire inspection report from the local fire department and have a written emergency plan that just affects the facility. These deficient practices could cause harm to all 8 (R #s 1-8) residents, identified on the resident census list provided by the Executive Director on 03/27/18, by having an unsafe building and not having an emergency plan that includes, a safe designated area to evacuate the residents in the event of an emergency, that only affects the facility. The findings are: A. Record review of the facility's building maintenance records book, revealed there was no documentation of a fire inspection being conducted by the local fire department. B. Record review of the facility's policy and procedure manual revealed there was no written emergency plan on what to do in the event of an emergency that affects just the facility and includes a safe designated area to evacuate residents to. C. On 03/27/18 at 2:00 pm, during interview with the Executive Director, she confirmed the facility has not had an annual fire inspection by the local fire department and there was no written emergency and/or evacuation policy for emergencies affecting just the facility.	A 022	A022 The Facility will obtain and file a fire inspection report from the local fire department as well an Emergency Plan that includes a safe designated area to evacuate the residents in the event of an emergency. The House Manager will ensure Fire Inspection Report is up to date and on file, and the Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	Sept 1, 2018

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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; (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;	A 025		

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A 025	Continued From page 6 (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 E Based on record review and interview, the facility failed to ensure that 2 (R #s 1 & 4) of 4 (R #s 1-4) resident's evaluations, sampled for compliance, had their evaluations completed and reviewed by a licensed practical nurse, registered nurse, or physician extender within 15 days of admission, and every 6 months or when a significant change in health occurs. This deficient practice could prevent residents from receiving the individual care or services needed if they are not identified on the evaluation. The findings are:	A 025		

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A 025	Continued From page 7 A. Record review of R #'s 1 file (admission date 03/08/18) revealed no documentation of an evaluation being completed. B. Record review of R #4's file (admission date 08/01/17), revealed her evaluation was completed on 07/24/17 , but was not signed as reviewed by the facility nurse until 11/29/17, 121 days after admission. C. On 03/27/18 at 10:40 am, during interview with the Executive Director, she confirmed that R #1 did not have an evaluation and R #4's evaluation was not reviewed by a nurse prior to admission.	A 025	A025 Resident Evaluations will be reviewed and if needed, revised by the House Manager and the facility registered nurse at the time the individual service plan is reviewed or when a significant change in health status occurs. To ensure accurate evaluations, the nurse will sign and date the facility evaluation form. The Administrator and/or Compliance Director will monitor nurse review and documentation to ensure continued compliance during quarterly in-house audits.	Sept 1, 2018
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	A 031		

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A 031	Continued From page 8 help in case of an emergency. A pay telephone does not fulfill this requirement. D. A list of emergency numbers including: fire department, police department, ambulance services and poison control shall be posted near each public telephone in the facility. [7.8.2.31 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.31 D Based on observation and interview, the facility failed to ensure a list of emergency phone numbers (fire, police, ambulance, and poison control, etc.) was posted near the facility's public phone in the common area. This deficient practice has the potential for all 8 (R #s 1-8) residents, identified on the resident census provided by the Executive Director on 03/27/18, to be at an increased risk of harm, illness, or injury if emergency services are delayed and first aid/medical treatment is not received. The findings are: A. On 03/29/18 at 10:00 am, during observation there were no emergency phone numbers posted next to the facility's public phone located in the common area where residents, staff, and visitors could see them. B. On 03/29/18 at 10:00 am, during interview with the Executive Director, she confirmed there is not a list of emergency phone numbers posted next the facility's phone in the common area.	A 031	A031 The Facility will ensure a list of emergency phone numbers (fire, police, ambulance, and poison control, etc) is posted near the public phone in the common area. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	Sept 1, 2018

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A 032	Continued From page 9	A 032		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 032		

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A 032	Continued From page 10 7.8.2.32 A (1) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP Individual Service Plan, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility	A 032		

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A 032	Continued From page 11 failed to ensure that 1 (R #7) of 1 (R #7) resident, whose internal incident reports were reviewed for compliance, was reported to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday. This deficient practice has the potential for all residents to be at risk of harm if the facility is not reporting incidents to the Licensing Authority then there would be no oversite to protect the residents from being abused, neglected, and/or injured. The findings are: A. Record review of R #7's Internal Incident Report dated 12/23/17, reported by Direct Care Staff (DCS #4) revealed resident had been complaining of chest, arm, jaw pain, and was hurting really bad. 911 was called and R #7 was transported to a medical center. The incident was not reported to the Licensing Authority. B. On 03/27/18 at 3:45 pm, during interview with the Executive Director, she confirmed R #7's Internal incident report dated 12/23/17 was not reported to the Licensing Authority.	A 032	A032 The Facility shall ensure that all suspected cases or known incidents of resident abuse, neglect, or exploitation are reported in accordance with NMAC. The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, and or welfare of the residents and staff to the licensing authority complaint hotmail within 24 hours or by the next business day. The Facility will be responsible for conducting and documenting the investigation of all incidents within 5 business days and will submit a copy of the report to the licensing authority. A copy of the report shall also be maintained on file at the facility. The Administrator will be responsible conducting and reporting known or suspected cases of abuse, neglect, or exploitation to the proper authorities. The Compliance Director will monitor continued compliance during quarterly in-house audits.	Sept 1, 2018
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant	A 033		

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BEEHIVE HOMES OF BERNALILLO 2	160 SHERIFFS POSSE RD BERNALILLO, NM 87004

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A 033	Continued From page 12 responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room;	A 033		

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	4026	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	180 SHERIFFS POSSE RD BERNALILLO, NM 87004

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A 033	Continued From page 13 (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (I) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical	A 033		

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A 033	Continued From page 14 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 (10) Based on observation and interview the facility failed to ensure the safety and welfare of 1 (R #1) of 1 (R #1) resident observed to have a physical restraint (full bed rail) in use. This deficient practice violates the resident's right to not be physically restrained. This deficient practice prevents residents from freely getting in and out of bed and could likely result in residents being injured if they get tangled up in the rails while attempting to climb around or over them to get out of bed. The findings are:	A 033		

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A 033	Continued From page 15 A. On 03/27/18 at 2:25 pm during observation of resident room #5, a physical restraint (full bed rail) was observed to be in use and was in the up-right position while R #1 was in bed. B. Record review of R #1's physician's orders revealed there were no orders for the use of a bed rail of any size. C. On 03/27/18 at 3:45 pm, during interview with the Executive Director, she confirmed R #1 has a full bed rail that is used in the up-right position when R #1 is in bed and there was no physician's order for any size bed rail.	A 033	A033 The Facility will ensure Residents' Rights to be free from physical restraint by avoiding the use of full bed rails. If and when bed rails become necessary for the safety of a resident, the Facility will obtain a physician's order to use rails of any size. The House Manager will ensure physician's orders are obtained and on file for use of bed rails of any size, and the Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	Sept 1, 2018
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 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	A 034		

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A 034	Continued From page 16 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 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	A 034		

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A 034	Continued From page 17 the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]	A 034		

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A 034	Continued From page 18 This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7) (9) (10) National Fire Prevention Association (NFPA) 99. 11.3 Cylinder and Container Storage Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1?2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall	A 034		

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A 034	Continued From page 19 comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection caps shall comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum:	A 034		

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A 034	Continued From page 20 CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING 2012 Edition Based on observation and interview the facility failed to ensure: 1. Oxygen cylinder tanks were secured, stored correctly, and an "oxygen in use" sign was posted outside the room. 2. Residents prescribed medications were available at the facility. 3. Discontinued medications were removed from the medication cart. This deficient practice has the potential for all 8 (R #s 1-8) residents identified on the census provided by the Executive Director on 03/27/18, to be at risk of harm, injury and death if: 1. Oxygen cylinder tanks were to be knocked over and may act like a missile. If a fire occurs, combustibles stored with oxygen cylinder tanks could accelerate the fire. 2. Prescribed medications are not available and taken as ordered. 3. Discontinued or unused medications are not removed immediately and may incorrectly be given to the resident and/or other residents. Findings related to Oxygen: A. On 03/27/18 at 9:35 am, during observation of resident room #5, 3 unsecured oxygen cylinder tanks were observed and no "oxygen in use" sign was posted on the outside of the door. B. On 03/27/18 at 9:57 am, during interview with the Executive Director, she confirmed there were 3 unsecured oxygen cylinder tanks stored in resident room #5 and no "oxygen in use" sign	A 034		

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A 034	Continued From page 21 was posted on the outside of the door. Findings related to Medication: C. On 03/28/18 at 2:50 pm, during observation of the medication cart, the following medications for R #1 were observed in the medication cart, but were not listed on the 03/27/18 - 03/28/18 Medication Administration Record (MAR): 1. Acetaminophen - Tylenol 650 mg (milligrams) (mild pain or fever) 1 suppository every 6 hours PRN (as needed). 2. Haloperidol - Haldol 2 mg/ml (agitation). Take 0.5 ml (milliliters) by mouth under tongue every 6 hours PRN. 3. Bisacodyl - Ducolax 10 mg - (constipation) suppository once a day PRN. 4. Prochlorper - prochlorperazine 10 mg - (nausea and vomiting) Take 1 tablet by mouth every 6 hours PRN. 5. Hysocyam - Anaspaz 0.125 mg (secretions)1 under tongue every 4 hours PRN. D. On 03/28/18 at 2:50 pm, during interview with Business Office Manager, she confirmed that the above medications for R #1 were in the medication cart but were not listed on the 03/27/18 - 03/28/18 MAR She stated that the medications are from hospice and they did not enter the medications on the MAR because they did not received the physicians orders. E. On 03/28/18 at 3:00 pm, during observation of the medication cart, the following medications for R #1 were observed in the medication cart, but were not listed the 03/27/18 - 03/28/18 MAR: 1. Fludrocort - Florinef 0.1 mg (hypotention) Take 1 tablet by mouth twice daily. 2. Senna Plus - Senexon 8.6/50 mg (constipation) Take 1 tablet by mouth every day.	A 034		

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A 034	Continued From page 22 3. Furosemide - Lasix 40 mg (edema) Take 1 by mouth a day. F. On 03/28/18 at 3:05 pm, during interview with the Business Office Manager, she confirmed the above medications for R #1 were in the medication cart, but were not listed on the 03/27/18 - 03/28/18 MAR. She stated that the medications were discontinued on 03/21/18 before resident came to the facility. G. On 03/28/18 at 3:40 pm, during observation of the medication cart, 2 bottles of Losartan - Cozaar 50 mg/12.5 mg (high blood pressure) were observed for R #2, but the medication was not listed on the February 2018, MAR. H. On 03/28/18 at 3:41 pm, during interview with the Office Manager, she confirmed the observation that 2 bottles of Losartan for R #2 were in the cart, but the medication was not listed on the February 2018 MAR and stated that the medication was discontinued on 11/27/17. I. On 03/28/18 at 3:44 pm, during observation of the medication cart, R #3s medication Polyethylene Glycol 3350 17 gm/dosage oral powder (constipation) - one packet mix in 8 oz. of water was observed to not be in the cart, but was still listed on the 03/01/18 - 03/28/18 MAR (as being given) and there was no physician's order for the medication to be discontinued. J. On 02/01/18 at 3:46 pm, during interview with the Business Office Manager, she confirmed R #3's Polyethylene Glycol 3350 was not in the cart, but was listed on the 03/01/18 - 03/28/18 MAR, and that there was no physician's order for the medication to be discontinued.	A 034	A034 The Facility will post "Oxygen In Use" signs outside of doors where oxygen is being utilized, and extra oxygen tanks will be secured according the the NFPA Cylinder and Container Storage Requirements. The House Manager will ensure daily compliance of these requirements, and the Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits. The Facility will obtain physician's orders to start, change, or discontinue medications, including PRN, and treatment for all Residents. All medications, including PRN, will be entered onto the Medication Administration Record (MAR). The House Manager will ensure day to day compliance, while the Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	Sept 1, 2018

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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 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.	A 035		

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A 035	Continued From page 24 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; (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;	A 035		

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	4026	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	180 SHERIFFS POSSE RD BERNALILLO, NM 87004

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A 035	Continued From page 25 (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 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;	A 035		

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A 035	Continued From page 26 (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 G (15) H Based on record review, observation, and interview the facility failed to ensure: 1. Physician orders for the use of bed rails were obtained and on file in the resident's chart. 2. Hospice medications were not accepted without physician orders and were placed on the Medication Administration Record (MARs) 3. The Medication Administration Records (MAR)s were complete, accurate and included all required pertinent information. These deficient practices have the potential to to cause serious illness or injury requiring	A 035		

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A 035	Continued From page 27 emergency medical treatment and even death to the 8 (R #s 1-8) residents on the census, provided by the Executive Director on 03/02/18 if: 1. Physician orders are not obtained to ensure the bed rails are only being used under the direction and supervision of the physician. 2. Medications are taken without the information/instructions from a physician. 3. Information on the MAR is not complete, accurate, and includes all required information, then medication errors could occur. The findings are: Findings related to Bedrails A. On 03/27/18 at 2:25 pm, during observation resident room (rr #5) full bedrails were observed in the up position while R #1 was in bed. B. On 03/27/18 at 2:28 pm, during observation of resident room (rr #6) half bedrails were observed in the up position while R #2 was in bed. C. On 03/27/18 at 2:30 pm, during observation of resident room (rr #7) half bedrails were observed on the bed in the down position for R #5. D. On 03/27/18 at 2:33 pm, during observation of resident room (rr #11) half bedrails were observed on the bed in the down position for R #5. E. Record review of R #s 1, 2, 5, 6 resident files, revealed there was no physicians orders for bed rails. F. On 03/27/18 at 3:45 pm, during interview with the Executive Director, she confirmed R #s 1, 2, 5 and 6 have bedrails and are using them without physician orders.	A 035		

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A 035	Continued From page 28 Findings related to Doctor's orders G. Record review of R #1s file revealed, that there were no physician orders for the following medications: 1. Acetaminophen - Tylenol 650 mg (milligrams) (mild pain or fever) 1 suppository every 6 hours PRN (as needed). 2. Haloperidol - Haldol 2 mg/ml (agitation). Take 0.5ml (milliliters) by mouth under tongue every 6 hours PRN. 3. Bisacodyl - Ducolax 10 mg - (constipation) suppository once a day PRN. 4. Prochlorper - prochlorperazine 10 mg - (nausea and vomiting) Take 1 tablet by mouth every 6 hours PRN. 5. Hysocyam - Anaspaz 0.125 mg (secretions)1 under tongue every 4 hours PRN. H. On 03/28/18 at 2:50 pm, during interview with Business Office Manager, she confirmed the above medications for R #1 the facility did not have the physicians orders and stated that the medications came from hospice. Findings related to MARs I. Record review of R #2's February 2018 and March 2018 MARs revealed, incorrect times when the following medications were to be taken: 1. Lexapro - Escitalopram 10 mg (depression), take 1 tablet daily at 8:00 am and the time on the MAR was listed to be taken at 9:00 am. 2. Loratadine - Claritin 10 mg (allergies), take 1 tablet daily at 8:00 am and the time on the MAR was listed to be taken at 9:00 am J. On 03/28/18 at 3:22 pm, during interview with	A 035	A035 The Facility will obtain physician's orders to start, change, or discontinue medications, including PRN, and treatment for all Residents. All medications, including PRN, will be entered onto the Medication Administration Record (MAR). When bed rails become necessary for the safety of a resident, the Facility will obtain a physician's order to use rails of any size. The House Manager will ensure physician's orders are obtained for all medications and for use of bed rails of any size. The House Manager will also ensure that physician orders are entered accurately on the MAR. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	Sept 1, 2018

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A 035	Continued From page 29 the Business Office Manager, she confirmed R #2's February 2018 and March 2018 MARs had incorrect times (9:00 am, instead of 8:00 am) when the above listed medications were to be taken.	A 035		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value	A 036		

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A 036	Continued From page 30 and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and	A 036		

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A 036	Continued From page 31 (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection.	A 036		

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A 036	Continued From page 32 (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days.	A 036		

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A 036	Continued From page 33 (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be	A 036		

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A 036	Continued From page 34 employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 B (4) D (4) Based on observation, record review, and interview the facility failed to ensure prepared food that is transported to resident's dining room from the adjoining facility, is maintained at the required hot temperatures of 140 degrees Fahrenheit (F), and they failed to keep temperature logs for both the refrigerator and the freezer. These deficient practices have the potential for all 8 (R #s 1-8) residents identified on the census provided by the Executive Director on 03/27/18, to be at risk of harm from foodborne illnesses if food is not maintained and served at the correct temperatures, and by possible contamination of foods stored in the refrigerator/freezer at incorrect temperatures. The findings are: A. On 03/27/18 at at 11:55 am, during	A 036	A036 The Facility will ensure that hot food temperatures are at minimum 140 degrees Fahrenheit. The Facility will also log refrigerator and freezer temperatures daily. The House Manager will ensure day to day compliance, and the Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	Sept 1, 2018

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A 036	Continued From page 35 observation of lunch items that were transported to the dining room from the facility next door, using the surveyors thermometer the temperature for the meatballs was 124.0 degrees F. B. On 03/27/18 at 11:58 am, during interview with the Executive Director, she confirmed the surveyors thermometer was calibrated at 32 degrees F and the temperature of the meatballs was 124 degrees F. C. Record review of the facilities temperature logs for the refrigerator and the freezer revealed the last date of both logs stopped on 03/08/18, 16 days prior. D. On 03/27/18 at 11:45 am, during interview with the Administrator, she confirmed there had been no daily temperatures recorded on the logs for the refrigerator and freezer since 03/08/18.	A 036		
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not	A 038		

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BEEHIVE HOMES OF BERNALILLO 2	180 SHERIFFS POSSE RD BERNALILLO, NM 87004

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A 038	Continued From page 36 be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 A C Based on observation and interview the facility failed to ensure the facility was cleaned as often as necessary to maintain a clean and sanitary environment and poisonous substances were not stored where residents could access them. These deficient practices have the potential for all 8 (R #s 1-8) residents identified on the census provided by the Executive Director on 03/27/18, to be at risk of injury and/or illness, due to contamination from an unsafe and dirty environment and poisonous or flammable substances that are not stored in a safe, locked location. The findings are: A. On 03/27/18 at 9:15 am, during observation of the unlocked laundry room, a large uncovered trash can was observed with soiled adult disposable briefs, that smelled and contaminated the clean linen that was washed and folded on a table along side the washer. B. On 03/27/18 at 09:20 am during observation of the unlocked cleaning supply closet, the following cleaning supplies were observed: 1. 2-25.2oz cans of powered cleaners.	A 038		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4026	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	160 SHERIFFS POSSE RD BERNALILLO, NM 87004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 038	Continued From page 37 2. 1-2 lb container of carpet fresher for pets. 3. 1-22 oz bottle of carpet Fresher. 4. 1-57.6 oz. bottle of pine cleaner. 5. 1-1 gallon bottle of window cleaner. C. On 03/27/18 at 09:25 am, during observation of Resident #11's bedroom, it had a strong smell of urine. D. On 03/27/18 at 10:05 am, during interview with the Executive Director, she confirmed that the laundry room had an uncovered trash can with soiled adult briefs, room #11 smelled of urine and the unlocked cleaning supply closet had chemicals that were accessible to residents.	A 038	A038 The Facility shall maintain a safe, clean, orderly, and attractive environment free of offensive odors and safety hazards. The House Manager will ensure the Laundry Room trash can is free of soiled disposable briefs and other incontinent supplies. Soiled disposable briefs and other incontinent supplies will be immediately removed from residents' rooms to prevent offensive odors. The House Manager will also ensure that cleaning supplies or hazardous chemicals are stored in a designated area where a coded entry lock will be installed to ensure residents cannot access them. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	Sept 1, 201
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 A	A 042		

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	4026	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	180 SHERIFFS POSSE RD BERNALILLO, NM 87004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 042	Continued From page 38 Based on observation and interview, the facility failed to maintain the riser/hot water heater room and keep it free of combustible items (buckets/cans of paint) that creates a fire hazard. This deficient practice could cause harm to all 8 (R #s 1-8) residents identified on the census list provided by the Executive Director on 03/27/18, if a fire were to occur because of the fire hazard created by the paint being stored in the riser/hot water room. The findings are: A. On 03/27/18 at 9:45 am, during observation, the following combustible items were observed next to the water heater: 1. 2-4.84 gallon buckets of paint. 2. 8-1 gallon cans of paint. B. On 03/27/18 at 10:05 am during an interview with the Executive Director, she confirmed that there were containers of paint stored in the riser/hot water room creating a fire hazard.	A 042	A042 The Facility will maintain the riser/water heater room, keeping it free of combustible items to avoid creating a fire hazard. The House Manager will ensure maintenance and continued compliance on a weekly basis. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits. All residents/staff have the potential to be affected by the deficient practice.	Sept 1, 2018
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	A 044		

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	4026	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	180 SHERIFFS POSSE RD BERNALILLO, NM 87004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 044	Continued From page 39 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 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 G Based on observation and interview, the facility	A 044		

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	4026	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	180 SHERIFFS POSSE RD BERNALILLO, NM 87004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 044	Continued From page 40 failed to provide screens on all operable windows. This deficient practice could cause harm and/or illness to all 8 (R #s 1-8) residents, identified on the census list provided by the Executive Director on 03/27/18, if bitten by germ carrying insects entering through unscreened windows. The findings are: A. On 03/27/18 at 9:45 am, during observation all the operable windows in the facility were observed to not have screens on them. B. On 03/27/18 at 10:05 am, during interview with the Executive Director, she confirmed all the windows were missing screens.	A 044	A044 The Facility will provide and maintain screens on all operable windows. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	Sept 30, 2018
A 059	7 NMAC 8.2.59 Windows WINDOWS: A. Each sleeping room shall be provided with an exterior window. (1) The window shall be operable, screened and have a clear operable area of 5.7 square feet minimum; measured twenty (20) inches wide minimum and measured twenty-four (24) inches high minimum. (2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor. B. Screens shall be provided on all operable windows. C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC,	A 059		

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	4026	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	180 SHERIFFS POSSE RD BERNALILLO, NM 87004

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A 059	Continued From page 41 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.59 B Based on observation and interview, the facility failed to provide screens on all operable windows. This deficient practice could cause harm to all 8 (R #s 1-8) residents, identified on the resident census list provided by the Executive Director on 03/27/18, by being bit by germ carrying insects entering through the unscreened windows. The findings are: A. On 03/27/18 at 9:45 am during observation, all the operable windows in the facility failed to have screens on them. B. On 03/27/18 at 10:05 am, during interview with the Executive Director, she confirmed that all the windows were missing screens.	A 059	A059 The Facility will provide and maintain screens on all operable windows. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	Sept 30, 2018
A 060	7 NMAC 8.2.60 Fire Clearence 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	A 060		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	180 SHERIFFS POSSE RD BERNALILLO, NM 87004

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A 060	Continued From page 42 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 B Based on record review and interview, the facility failed to have a copy of an annual fire inspection from the local fire prevention authority or documentation that one had been requested. The Administrator could not find the original fire inspection conducted prior to opening either. This deficient practice could cause harm, injury or death to all 8 (R #s 1-8) residents identified on the census list provided by the Executive Director on 03/27/18, if a fire were to occur and there had been no inspection by the local fire authority to check for fire safety hazards. The findings are: A. Record review of the facility's building maintenance records book, revealed no documentation that a fire inspection had been conducted by the local fire department. B. On 03/27/18 at 2:00 pm, during interview with the Executive Director, she confirmed she did not have an annual fire inspection done and she could not find the inspection from the fire department prior to opening.	A 060	A060 The Facility will obtain and file a fire Inspection report from the local fire department as well an Emergency Plan that includes a safe designated area to evacuate the residents in the event of an emergency. The House Manager will ensure Fire Inspection Report is up to date and on file, and the Administrator and/or Compliance Director will monitor continued compliance during quarterly In-house audits.	Sept 1, 2018
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes	A 070		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	180 SHERIFFS POSSE RD BERNALILLO, NM 87004

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A 070	Continued From page 43 INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.70 F .1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP Individual Service Plan, or any	A 070		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	160 SHERIFFS POSSE RD BERNALILLO, NM 87004

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A 070	Continued From page 44 other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure that 1 (R #7) of 1 (R #7) resident, whose internal incident reports were reviewed for compliance, was reported to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday. This deficient practice has the potential for all residents to be at risk of harm if the facility is not reporting incidents to the Licensing Authority then there would be no oversite to protect the residents from being abused, neglected, and/or injured. The findings are: A. Record review of R #7's internal Incident Report dated 12/23/17, reported by Direct Care Staff (DCS #4) revealed resident had been	A 070		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BERNALILLO 2	180 SHERIFFS POSSE RD BERNALILLO, NM 87004

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A 070	Continued From page 45 complaining of chest, arm, jaw pain, and was hurting really bad. 911 was called and R #7 was transported to a medical center. The incident was not reported to the Licensing Authority. B. On 03/27/18 at 3:45 pm, during interview with the Executive Director, she confirmed R #7's internal incident report dated 12/29/17 was not reported to the Licensing Authority.	A 070	A070 The Facility shall ensure that all suspected cases or known incidents of resident abuse, neglect, or exploitation are reported in accordance with NMAC. The Facility will be responsible for conducting and documenting the investigation of all incidents within 5 business days and will submit a copy of the report to the licensing authority. A copy of the report shall also be maintained on file at the facility. The Administrator will be responsible conducting and reporting known or suspected cases of abuse, neglect, or exploitation to the proper authorities. Compliance Director will monitor continued compliance during quarterly in-house audits.	Sept 1, 2018