PRINTED: 10/16/2018
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4037	A. BUILDING: _____ B. WING _____	08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF WHITE ROCK	110 LONGVIEW DRIVE WHITE ROCK, NM 87544

(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 as a result of an initial survey conducted on 08/17/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.	A 000		
A 008	7 NMAC 8.2.8 General Licensing Requirements GENERAL LICENSING REQUIREMENTS: A. Licensure is required. No person or entity shall establish, maintain or operate an assisted living facility without first obtaining a license. B. Application for licensure. An initial or renewal application shall be made on the forms prescribed by and available from the licensing authority. The issuance of an application form is not a guarantee that the completed application will be accepted, or that the department will issue a license. Information provided by the facility and used by the licensing authority for the licensing process shall be accurate and truthful. The licensing authority will not issue a new license if the applicant has had a health facility license revoked or renewal denied or has surrendered a license under threat of revocation or denial of renewal. The licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of applicable rules found to be class A or class B deficiencies as defined in Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC or has been non-compliant with plans of correction. The licensing authority will not issue a license until the applicant has supplied all of the information that is required by this rule. Any facility that fails to participate in good faith by falsifying information presented in the licensing process shall be denied licensure by the department. The following information shall be submitted to the licensing authority for approval:	A 008	NM Department of Health OCT 31 2018 Division of Health Improvement	

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	10/30/18

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A 008	Continued From page 1 (1) a letter of intent that includes the proposed physical address, the primary population of the facility and a summary of the proposed services; after the letter of intent has been received, an application packet including; the application form, fee schedule and the licensing rule will be issued to the applicant by the licensing authority; (2) the completed and notarized application and the appropriate non-refundable fee(s); (3) a program narrative identifying and detailing the geographic service area, the primary population including any special needs requirements, along with a full description of the services that the applicant proposes to provide including: (a) a description of the characteristics of the proposed population of the facility; (b) a description of the services and care that will be provided to the residents; (c) a description of the anticipated professional services to be offered to the residents; and (d) a description of the facility ' s relationship to other services and related programs in the service area and how the applicant will collaborate with them to achieve a system of care for the residents. (4) policies and procedures annotated to this rule; (5) evidence to establish that the applicant has sufficient financial assets to permit operation of the facility for a period of six (6) months; the evidence shall include a credit report from one of the three recognized credit bureaus with a minimum credit score of six-hundred fifty (650) or above; (6) copies of organizational documents to include the following list of items: (a) the names of all persons or business entities that have at least five percent (5%) ownership interest in the facility, whether direct or indirect	A 008		

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A 008	Continued From page 2 and whether in profits, land or building; this includes the owners of any business entity which owns all or part of the land or building; (b) the identities of all creditors that hold a security interest in the premises, whether land or building; (c) any changes in ownership or management shall be reported to the department within thirty (30) days; (7) building plans as required at 7.8.2.41 NMAC of this rule; (8) fire authority approval as required at 7.8.2.60 NMAC of this rule; (9) a letter of approval or exemption from the local health authority having jurisdiction for the food service and the kitchen facility; (10) a copy of liquid waste disposal and treatment system permit from local health authority having jurisdiction; (11) approval from local zoning authority; (12) building approval (certificate of occupancy); and (13) any other information that the applicant wishes to provide or that the licensing authority may request. C. Application for amended license. A licensee shall submit an application for an amended license and the required non-refundable fee to the licensing authority prior to a change with the facility. An amended license is required for a change of: location, administrator, facility name, capacity or any modification or addition to the building. (1) An application for a change of the facility administrator or change of the administrator's name shall be submitted to the licensing authority within ten (10) business days of the change. (2) An application for increase in capacity shall be accompanied by a building plan pursuant to	A 008		

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A 008	Continued From page 3 7.8.2.41 NMAC of this rule. A facility shall not increase census until the licensing authority has reviewed and approved the increase and has issued a new license that reflects the approved increase in capacity. D. Application for license renewal. Each facility shall apply for a renewal of the annual license within thirty (30) business days prior to the license expiration date by submitting the following items: (1) an application and the required fee; (2) an updated program narrative, if the facility has changed the program or the focus of services; (3) the annual fire inspection report; and (4) the licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of this rule or has been noncompliant with plans of correction or payment of civil monetary penalties. E. License. Any person or entity that establishes, maintains or operates an assisted living facility shall obtain a license as required in this rule before accepting residents for care or providing services. (1) Each facility that provides care or treatment shall obtain a separate license. The license is non-transferable and is only valid for the facility to which it is originally issued and for the owner or operator to whom it is issued. It shall not be sold, reassigned or transferred. (2) The maximum capacity specified on the license shall not be exceeded. (3) If the facility is closed and the residents are removed from the facility, the license shall be returned to the licensing authority. Written notification shall be issued to all residents or the residents ' surrogate decision maker and the licensing authority at least thirty (30) calendar days prior to the closure.	A 008		

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A 008	Continued From page 4 F. Temporary license. (1) A temporary license may be issued to a new facility before residents are admitted provided that the facility has met all of the life safety code requirements as stated in this rule and policies and procedures for the facility have been reviewed and approved. (2) Upon receipt of a temporary license, the facility may begin to admit up to three (3) residents. (3) After the facility has admitted up to three (3) residents, the facility operator or owner shall request an initial health survey from the licensing authority. (4) Following a determination of compliance with this rule by the licensing authority, an annual license will be issued. The renewal date of the annual license is based on the initial date of the first temporary license. (5) The licensing authority has the right to determine compliance or noncompliance. (6) A temporary license shall cover a period of time, not to exceed one hundred twenty (120) calendar days. (7) No more than two (2) consecutive temporary licenses shall be issued. If a second temporary license is issued, an additional non-refundable fee is required. If all requirements are not met within the two hundred forty (240) day time frame, the applicant shall repeat the application process. G. Annual license. An annual license is issued for one (1) year for a facility that has met all the requirements of this rule. H. Display of license. The facility shall display the license in a conspicuous public place that is visible to residents, staff and visitors. I. Unlicensed facilities. Any person or entity that opens or maintains an assisted living facility without a license is subject to the imposition of	A 008		

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A 008	Continued From page 5 civil monetary penalties by the licensing authority. Failure to comply with the licensure requirements of this rule within ten (10) days of notice by the licensing authority may result in the following penalties pursuant to Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC. (1) A civil monetary penalty not to exceed five-thousand dollars ($5,000) per day. (2) A base civil monetary penalty, plus a per-day civil monetary penalty, plus the doubling of penalties as applicable, that continues until the facility is in compliance with the licensing requirements in this rule. (3) A cease and desist order to discontinue operation of a facility that is operating without a license. (4) Additional criminal penalties may apply and shall be imposed as necessary. [7.8.2.8 NMAC - Rp, 7.8.2.8 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.8 H Based on observation and interview the facility failed to ensure that the Assisted Living License was displayed in a conspicuous public place where residents, staff, and visitors can see it. If the facility's license is not displayed in a conspicuous public place then the 13 (R #s 1-13) residents listed on the census, provided by the Operations Manager on 08/15/18, visitors, and staff will not know if the facility has and is maintaining a current license as an Assisted Living Facility. The findings are: A. On 08/15/18 at 10:46 am, during an observation, the facility's temporary Assisted	A 008		

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A 008	Continued From page 6 Living license was observed to be posted in the office/medication room and was not located in public place where all residents, staff, and visitors could see it. B. On 09/15/18 at 11:00 am, during an interview with the Operations Manager, he confirmed that the facility's temporary Assisted Living license was not posted in a conspicuous place where residents, staff, and visitors can see it.	A 008	A008 The Facility will display in a conspicuous public place the Assisted Living License where residents, staff, and visitors can see it. The Operations Manager will ensure the license is current and posted in a conspicuous place, and the Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	11/1/18
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and	A 016		

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A 016	Continued From page 7 (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC.	A 016		

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A 016	Continued From page 8 [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.16 A Based on observation and interview the facility failed to ensure that the facility had a full-time Administrator within 40 miles of the facility in order to provide supervision. This deficient practice has the potential to affect the safety and welfare of all 13 (R #s 1-13) residents listed on the census provided by the Operations Manager on 08/15/18, if there is no full time administrator to supervise the facility and to oversee the care being provided to the residents. The findings are: A. On 08/15/18 at 10:46 am, during an observation it was revealed, that the Administrator listed on the license was over 40 miles away from the facility so there was no full-time Administrator within 40 miles to supervise the facility. B. On 08/15/18 at 11:40 am, during an interview with the Owner, he confirmed that there was no full-time Administrator to supervise the facility within 40 miles.	A 016	A016 **The Facility has designated a full-time Administrator within 40 miles of the facility in order to provide supervision. The Compliance Director will monitor Continued compliance during quarterly in-house audits.**	11/15/18
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	A 020		

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

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A 020	Continued From page 10 (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as	A 020		

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A 020	Continued From page 11 determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the	A 020		

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A 020	Continued From page 12 other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 B (4) Based on record review, observation, and interview the facility failed to convene a team meeting for 1 (R #2) of 1 (R #2) resident who had a physical restraint (full bedrails) in use. This deficient practice has the potential for residents to be at risk or harm, injury, or death if a team meeting was not convened to ensure the facility could meet the needs of a resident who has full bedrails in use and preventive measures were in	A 020		

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	4037	A. BUILDING: _____ B. WING _____	08/17/2018

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A 020	Continued From page 13 place to prevent falls or residents becoming entangled in, climbing over or around the bedrails. The findings are: A. On 08/15/18 at 11:07 am, during an observation of resident room #4, R #2 was observed in a hospital bed with full bedrails in the up right position. B. Record review of R #2's resident file revealed no documentation that a Admission/Retention Exception meeting was convened prior to being admitted to the facility on 04/28/18 with full bedrails. C. On 08/15/18 at 3:41 pm, during an interview with the Operations Manager and Regional Administrator, they confirmed that there was no Admission/Retention Exception team meeting convened to ensure the facility could meet the needs of R #2 who had full bed rails in use on his hospital bed and preventive measures were in place to prevent falls or becoming entangled in, climbing over, or around the full bedrails.	A 020	A020 The Facility will convene a team meeting or coordinate care conference to discuss and document conditions or circumstances that require continuous use of bedrails for Resident #2. The Operations Manager will ensure the meeting is conducted and the results are documented. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	11/15/18
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	A 022		

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A 022	Continued From page 14 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, 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;	A 022		

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A 022	Continued From page 15 (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; (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	A 022		

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A 022	Continued From page 16 (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, 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	A 022		

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A 022	Continued From page 17 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] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (10) (b) (13) Based on record review and interview the facility failed to ensure that: 1. There was a written emergency evacuation plan for community wide disasters. 2. Current vaccination records for the pets (dogs) were on file at the facility. These deficient practices have the potential for all 13 (R #s 1-13) residents listed on the census, provided by the Operations Manager on 08/15/18 to be at risk of harm, injury, illness and/or death if:	A 022		

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A 022	Continued From page 18 1. A community wide disaster occurred and the residents were unable to be safely evacuated from the community. 2. The pets do not have current vaccinations and residents are bitten or contract communicable diseases. The findings are: Findings related to emergency plan A. Record request for the emergency evacuation plan for community wide disasters revealed, no documentation that the facility had a plan in place. B. On 08/16/18 during an interview with the Operations Manager and the Regional Administrator, they confirmed that the facility does not have a written emergency evacuation plan for community wide disasters. Findings related to pet vaccinations C. Record request for the vaccinations for the 2 dogs living at the facility, revealed no documentation that the dogs had current vaccinations. D. On 08/16/18 at 2:56 pm, during an interview with the Regional Administrator, they confirmed that there were no current vaccination records for the 2 dogs on file at the facility.	A 022	A022 (1) The Facility will ensure there is a written evacuation plan for community wide disasters. (2) The Facility will ensure current vaccination records for pets are on file at the facility. The Operations Manager will ensure written evacuation plans for community wide disasters and current pet vaccination records are on file. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	11/16/18
A 023	7 NMAC 8.2.23 Pets PETS: Pets are permitted in a licensed facility, in accordance with the facility's rules. A. Prohibited areas. Animals are not permitted in	A 023		

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A 023	Continued From page 19 food processing, preparation, storage, display and serving areas, or in equipment or utensil washing areas. Guide dogs for the blind and deaf and service animals for the handicapped shall be permitted in dining areas pursuant to Subsection K of 7.8.2.9 NMAC. B. Vaccination. Pets shall be vaccinated in accordance with all state and local requirements and records of such vaccination shall be kept on file in the facility. [7.8.2.23 NMAC - Rp, 7.8.2.24 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.23 B Based on Record review and interview the facility failed to ensure that the pets (2 dogs) who live in the facility had current vaccinations and the vaccination records were on file at the facility. This deficient practice has the potential for all 13 (R #s 1-13) residents listed on the census provided by the Operations Manager on 08/15/18 to be a risk of harm or illness, if the residents are bitten or contract communicable diseases from pets who do not have current vaccinations. The findings are: A. Record request for the vaccinations for the 2 dogs revealed, no documentation that the dogs had current vaccinations. B. On 08/15/18 at 2:56 pm, during interview with the Regional Administrator, she confirmed that there were no current vaccination records for the 2 dogs on file at the facility.	A 023	11/15/18 A023 The Facility will ensure current vaccination records for pets are on file at the facility. The Operations Manager will ensure current pet vaccination records for all pets are on file. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	

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A 025	Continued From page 20	A 025		
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	A 025		

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A 025	Continued From page 21 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 B C (10) E Based on record review and interview the facility failed to ensure that 4 (R #s 1-4) of 4 (R #s 1-4 residents whose evaluations/assessments were reviewed for compliance were: 1. Completed with required diagnosis information. 2. Reviewed by licensed practical nurse (LPN) registered nurse (RN) or physician extender (PE). This deficient practice has the potential to delay care, services, and assistance the residents may	A 025		

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A 025	Continued From page 22 need, resulting in possible complications, and the need for medical intervention. The findings are: A. Record Review of R #1's resident file revealed, that the evaluation dated 01/08/18 was missing the resident's diagnoses. B. Record review of R#2's resident file revealed, that the evaluation dated 04/14/18 was missing the resident's diagnoses. C. Record review of R#3's resident file revealed, that the evaluation dated 06/19/18 was missing the resident's diagnoses and was not signed as reviewed by nurse. D. Record review of R #4's resident file revealed, that the evaluation dated 07/31/18 was missing the resident's diagnoses. E. On 08/15/18 at 2:15 pm, during an interview with the Regional Administrator, she confirmed that: 1. R #1, 3, and 4's evaluations were missing the diagnoses. 2. R #3's evaluation was missing the diagnoses and was not signed as reviewed by a nurse.	A 025	**A025** **The Facility will ensure Resident Evaluations/Assessments are reviewed for required diagnosis information by a licensed practical nurse, registered nurse, or physician extender. All current residents' evaluations were reviewed and corrections made. The Operations Manager will ensure Resident Evaluations/Assessments will document diagnosis and the Nurse will sign the evaluation as reviewed. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.**	11/15/18
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	A 033		

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A 033	Continued From page 23 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 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	A 033		

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A 033	Continued From page 24 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; (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	A 033		

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(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 033	Continued From page 25 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 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: 7.8.33 D (10) Based on record review, observation, and interview the facility failed to ensure for 1 (R #2) of 1 (R #2) resident who had a physical restraint (full bedrails) in use was free of being physically	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4037	A. BUILDING: _____ B. WING _____	08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF WHITE ROCK	110 LONGVIEW DRIVE WHITE ROCK, NM 87544

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A 033	Continued From page 26 restrained. This deficient practice has the potential for residents to be at risk of harm, injury, or death if physical restraints (full bedrails) are being used and the resident falls or becomes entangled in, climbs over or around the bedrails. The findings are: A. On 08/15/18 at 11:07 am, during an observation of resident room #4, R #2 was observed in a hospital bed with full bedrails in the up right position. B. Record review of R #2's resident file revealed no documentation of: 1. A physicians order for the use of full bedrails. 2. No documentation that an admission/retention exception team meeting was convened prior to being admitted to the facility on 04/28/18 with full bedrails. 3. There was no documentation that preventive measures were in place to prevent falls or becoming entangled in, climbing over, or around the full bedrails. C. 08/15/18 at 3:41 pm, during an interview with the Operations Manager and Regional Administrator, they confirmed that there was no: 1. No physician's order for the use of full bedrails for R #2. 2. Admission/retention exception team meeting convened to ensure the facility could meet the needs of R #2 who had full bedrails in use on his hospital bed. 3. Preventive measures were in place to prevent falls or becoming entangled in, climbing over, or around the full bedrails.	A 033	**A033** **The Facility will obtain a physician's order for use of bedrails and will convene a team meeting or coordinate care conference to discuss and document conditions or circumstances that require continuous use of bedrails for Resident #2. The Operations Manager will ensure the orders are obtained and the meeting is conducted and the results are documented. In the future, The Operations Manager will ensure orders are obtained and a care conference is convened prior to or on Admission for bedrails. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.**	11/15/18

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A 034	Continued From page 27	A 034		
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 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.	A 034		

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A 034	Continued From page 28 (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 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	A 034		

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A 034	Continued From page 29 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] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7) refer to: NFPA (National Fire Prevention Association) 99. 2012 Edition. 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	A 034		

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A 034	Continued From page 30 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 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	A 034		

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A 034	Continued From page 31 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: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING Based on observation and interview the facility failed to ensure that oxygen cylinder tanks were secured and stored correctly. This deficient practice has the potential for all 13 (R #s 1-13) residents identified on the census provided by the Operations Manager on 08/16/18, to be at risk of harm or injury if oxygen cylinder tanks were to be knocked over and may act like a missile, and if a fire occurs, oxygen cylinder tanks stored with combustibles accelerates the fire. The findings are: A. On 8/15/18 at 10:59 am, during an observation of R #5's room, 7 small oxygen	A 034		

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A 034	Continued From page 32 cylinder tanks were observed being stored in the closet with combustibles - clothes, shoes, and blankets. B. On 08/15/18 at 11:03 am, during an observation of R #6's room, 7 secured small oxygen cylinder tanks were observed being stored in residents room, which exceeds the amount allowed (1 cylinder tank for emergency use). C. On 08/15/18 at 11:26 am, during an observation of R #7's room, 5 unsecured oxygen cylinder tanks were observed being stored in the resident's room. E. On 08/15/18 at 11:28 am, during an interview with the Operations Manager, he confirmed that the following was observed: 1. R #5 had 7 small oxygen cylinder tanks stored in the closet with combustibles - clothes, shoes, and blankets. 2. R #6 had 7 small oxygen cylinder tanks being stored in the residents room. 3. R #7 had 5 unsecured oxygen cylinder tanks were being stored in residents room.	A 034	**A034** **The Facility will ensure that oxygen cylinder tanks are secured and stored correctly, and away from combustibles such as can be found in Residents' rooms and closets. The Operations Manager will ensure the oxygen cylinder tanks are stored securely and separately in a designated room with no other combustable items. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.**	11/15/18
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 035		

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A 035	Continued From page 33 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 nata) 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	A 035		

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A 035	Continued From page 34 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; (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	A 035		

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A 035	Continued From page 35 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; (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	A 035		

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A 035	Continued From page 36 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; 7.8.2.35 G (5) Based on record review and interview the facility failed to ensure the safety and welfare for 2 (R #s 2 & 4) of 2 (R #s 2 & 4) residents who did not having physician orders for the use of bedrails (half & full). This deficient practice has the potential for residents to be at risk or harm, injury, or death if bedrails are being used without the physicians knowledge and written orders and the resident falls or becomes entangled in, climbs over or around the bedrails. The findings are: A. Record review of R #s 2 & 4's resident files revealed, no documentation of a physician's order for the use of bedrails. B. On 08/15/18 at 3:41 pm, during an interview with the Operations Manager and Regional Administrator, they confirmed there were no physician orders for R #s 2 & 4's bedrails. Based on record review and interview the facility failed to ensure that the Medication Administration Records (MARs) for 4 (R #s 1-4)	A 035		

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A 035	Continued From page 37 of 4 (R #s 1-4) residents included both the brand/generic names of medications. If the MARs do not include both the brand/generic name of the medications, then residents may be at risk of harm or illness, and need medical treatment if the Direct Care Staff (DCS) do not recognize the name of the medication, which may result in medication errors occurring because vital information is missing on the MAR. The findings are: A. Record review of R #1's August 2018 MAR revealed that the brand/generic is missing for the following medications: 1. Clopidogrel Bisulfate - Plavix (blood thinner) 75 mg (milligrams) take 1 tablet by mouth daily. 2. Donepezil Hydrochloride - Aricept (dementia) 5 mg take 1 tablet by mouth at bedtime. 3. Hydrochlorothiazide (HCTZ) - (blood pressure) 25 mg take 1 tablet by mouth at 8:00 pm. 4. Imodium - Loperamide (diarrhea) 2 mg PRN (as needed) take 1 tablet by mouth every 6 hours. 5. Lantus - Insulin Glargine (diabetes) 100 units/ml (milliliters) take 36 units subcutaneous at bedtime. 6. Lisinopril - Zestril (blood pressure) 20 mg take 1 tablet by mouth once a day at am (morning). 7. Metformin - Glucophage (diabetes) 500 mg take 1 tablet with meals twice a day am and pm (evening). 8. Novolog FlexPen - insulin (diabetes) 100 units/ml set dial to 5 on flex pen and inject subcutaneously if blood sugar is above 200 before dinner. 9. Simvastatin - Zocor (Cholesterol) 20 mg	A 035		

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	4037	A. BUILDING: _____ B. WING _____	09/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 035	Continued From page 38 take 1 tablet by mouth daily at bedtime. 10. Tylenol - acetaminophen (pain) 325 mg PRN take 1 tablet every four hours as needed. B. Record review of R #2's August 2018 MAR revealed that the brand/generic is missing for the following medications: 1. Clopidogrel Bisulfate - Plavix (blood thinner) 75 mg take 1 tablet by mouth once daily at 9:00 am. 2. Lisinopril - Zestril (blood pressure) 2.5 mg take 1 tablet by mouth at 9:00 am. C. Record review of R #3's August 2018 MAR revealed that the brand/generic is missing for the following medications: 1. Acetaminophen - Tylenol (pain) 500 mg PRN take 1 tablet by mouth every 6 hours. 2. Aspirin - Bayer (heart disease) 81 mg take 1 tablet by mouth once a day. 3. Bystolic - Nebivolol (heart failure) 5 mg take 1 tablet by mouth once a day at 8:00 am. 4. Digox - Lanoxin (blood pressure) 125 mcg (micrograms) by mouth once a day for heart rate. 5. Furosemide - Lasix (edema) 40 mg take 1 tablet by mouth once a day in the morning. 6. Imodium AD - Loperamide (Diarrhea) 2 mg PRN take 1 tablet by mouth as needed twice a day. 7. Isosorbide Monoitrate Extended Release - Nitrate (chest pain) 30 mg take 1 tablet by mouth once a day in the morning. 8. Klor-Con - Potassium Chloride (low potassium) 100 mg take 1 tablet by mouth once a day in the morning. 9. Losartan Potassium - Cozaar (high blood pressure) 100 mg take 1 tablet by mouth once a day in the morning. 10. Metolazone - Zaroxolyn (edema) 2.5 mg take 1 tablet by mouth at 8:00 am.	A 035		

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A 035	Continued From page 39 11. Spironolactone - Aldactone (edema) 25 mg take 1 tablet by mouth once daily with food. D. Record review of R #4's August 2018 MAR revealed that the brand/generic is missing for the following medications: 1. Calcium Carbonate - Tums (indigestion) 500 mg PRN chew 1 500 (mg) tablet by mouth every 6 hours as needed. 2. Colace - Docusate Sodium (constipation) 100 mg PRN take 1 tablet by mouth twice daily as needed. 3. Hyoscyamine Sulfate - Levsin (secretions) 0.125 mg PRN take 1 tablet by mouth every 4 hours as needed. 4. Lorazepam - Ativan (anxiety) 0.5 mg PRN take 1 tablet by mouth every 6 hours as needed. 5. Melatonin - Methoxytryptamine (insomnia) 5 mg PRN take 5 mg by mouth daily at bedtime. 6. Nitroglycerin - Nitrostat (chest pain) 0.4 mg PRN take 1 tablet under the tongue every 5 minutes times three doses only as needed for chest pain. 7. Ondansetron - Zofran (nausea and vomiting) 4 mg PRN take 1 tablet by mouth every 4 hours as needed. E. On 08/15/18 at 3:30 pm, during an interview with the Regional Administrator, she confirmed R #s 1-4's August 2018 MARs were missing the brand/generic names for the above listed medications.	A 035	A035 The Facility will obtain a physician's order for use of bedrails and will convene a team meeting or coordinate care conference to discuss and document conditions or circumstances that require continuous use of bedrails for Resident #2. The Operations Manager will ensure the orders are obtained and the meeting is conducted and the results are documented. In the future, The Operations Manager will ensure orders are obtained and a care conference is convened prior to or on Admission for bedrails. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits. The Facility will ensure the Medication Administration Records (MAR) will include both brand/generic names of medications so that Direct Care Staff will recognize the name of the medication and avoid medication errors. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	11/15/18
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	A 036		

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A 038	Continued From page 40 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 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	A 038		

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A 036	Continued From page 41 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 (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,	A 036		

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A 038	Continued From page 42 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. (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	A 038		

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A 038	Continued From page 43	A 038		

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.
(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

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A 036	Continued From page 44 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 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	A 036		

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A 036	Continued From page 45 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 A (d) D (5) Based on observation and interview the facility failed to ensure that: 1. The posted weekly menu was current. 2. Cleaning supplies were not kept in the same storage area as food for the residents. These deficient practices have the potential for the 13 (R #1-13) residents listed on the census, provided by the Operations Manager on 08/15/18 to: 1. Not know what is actually being served for each meal during the week. 2. To be at risk of harm, illness, or death if the food becomes contaminated with chemicals and the residents ingest the contaminated food. The findings are: Findings related to menu A. On 08/15/18 at 10:52 am, during an observation the posted weekly menu was observed to be for 04/30/18 to 05/06/18 B. On 08/15/18 at 10:53 am, during an interview with Direct Care Staff (DCS) #5, she confirmed that the posted weekly menu was not for the current week.	A 036	A036 The Facility shall display current weekly menus. The Operations Manager will update and display current menus on a weekly basis.The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits. The Facility will ensure cleaning supplies are not kept in the same storage areas as the food for residents. The Operations Manager will store cleaning supplies apart from residents' food supplies. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	11/16/18

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A 036	Continued From page 48 C. On 08/15/18 at 2:55 pm, during an observation of the pantry there was 1-32 ounce bottle of degreaser cleaner in with the residents food. D. On 08/15/18 at 3:05 pm, during an interview with the Operations Manger, he confirmed that the degreaser cleaner was stored in the pantry with the residents' food.	A 036		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at	A 037		

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A 037	Continued From page 47 least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (10) Based on observation and interview, the facility failed to ensure cleaning supplies were kept in a secured room or closet. The deficient practice has the potential for all 13 (R #s 1-13) residents identified on the resident census provided by the Operations Manager on 08/15/18, to be at risk of harm or injury if they were to ingest or spill cleaning supplies on their face or body. The findings are: A. On 08/15/18 at 10:15 am, during an observation of the laundry room, the following	A 037		

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A 037	Continued From page 48 cleaning supplies were observed being stored in an unsecured cabinet and accessible to residents: 1. 2-1 gallon bottles of bleach. 2. 1-96 fl (fluid) oz (ounce) bottle of bleach. 3. 3-46.5 oz laundry detergent. B. On 08/15/18 at 11:11 am, during an interview with Direct Care Staff (DCS) #2, she confirmed that the following unsecured cleaning supplies were being stored in the laundry room and accessible to residents: 1. 2-1 gallon bottles of bleach. 2. 1-96 fl oz bottle of bleach. 3. 3-46.5 oz laundry detergent. C. On 08/15/18 at 10:55 am, during an observation of the Hall Broom Closet, the following cleaning supplies and chemicals were observed being stored in an unsecured cabinet and accessible to residents: 1. 1-304 fl oz bottle of cleaner. 2. 1-16 oz can spray paint. 3. 1-4 pk (pack) toilet cleaners. 4. 1-16 oz can spray foam insulation. 5. 1-20 oz can glass cleaner. 6. 1-128 fl oz bottle liquid cleaner. 7. 5-19 oz cans disinfectant spray. 8. 2-70 ct (count) containers of disinfectant wipes. 9. 2-28 oz bottles of toilet cleaner. 10. 1-8 oz can spray lubricant. D. On 08/15/18 at 11:00 am, during an interview with the Operations Manager, he confirmed that the following cleaners and chemicals were stored in an unsecured room and accessible to	A 037		

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A 037	Continued From page 49 residents: 1. 1-304 fl oz bottle of cleaner. 2. 1-16 oz can spray pant. 3. 1-4 pk toilet cleaners. 4. 1-16 oz can spray foam insulation. 5. 1-20 oz can glass cleaner. 6. 1-128 fl oz bottle liquid cleaner. 7. 5-19 oz cans disinfectant spray. 8. 2-70 ct containers of disinfectant wipes. 9. 2-28 oz bottles of toilet cleaner. 10. 1- 8 oz can spray lubricant. E. On 08/15/18 at 2:55 pm, during an observation of the food pantry, 1-32 oz bottle of degreaser spray was observed being stored in an unsecured room and accessible to residents. F. On 08/15/18 at 3:05 pm, during an interview with Operations Manager and Regional Administrator, they confirmed that 1-32 oz bottle of degreaser spray was being stored in an unsecured room and accessible to residents.	A 037	A037 The Facility will ensure cleaning supplies are kept secure in a secure room or closet. The Operations Manager will install electronic door locks for the Laundry Room and the Janitor's Closet to ensure cleaning supplies and other chemicals are secure. Current Staff will also be retrained regarding the proper storage and how to secure chemicals. This training will be included in Employee Orientation for future staffers. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	11/15/18
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	A 038		

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	4037	A. BUILDING: _____ B. WING _____	08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF WHITE ROCK	110 LONGVIEW DRIVE WHITE ROCK, NM 87544

(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 50 stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not 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: 7.8.38 A B Based on observation and interview the facility failed to ensure: 1. That the exterior electrical room was free of safety hazards and had a working clearance of 36" in front of the electrical panels. 2. That combustibles and flammable items were stored in approved locked closed metal cabinets in well ventilated areas. This deficient practice has the potential for all 13 (R #s 1-13) residents listed on the resident census provided by the Operations Manager on 08/15/18, to be at risk of illness, injury and/ or death if: 1. A fire or other emergency requiring immediate access to the electrical panel and the working area are not maintained. 2. In case of fire combustible and flammable items allowed vapors to spread throughout the building and has the possibility of igniting, creating a major fire.	A 038		

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	4037	A. BUILDING: _____ B. WING _____	08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF WHITE ROCK	110 LONGVIEW DRIVE WHITE ROCK, NM 87544

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A 038	Continued From page 51 The findings are: A. On 8/15/18 at 11:55 am, during an observation of the electric room located on the exterior of the building containing (3) electric boxes, cable TV/DSL, and telephone system wires/boxes. The following was observed: 1. The door of the electrical room was unlocked 2. The working clearance to the electric boxes was blocked by building supplies. 3. Hazardous material were stored in the electrical room: a. 4-5 gallon buckets of paint, b. 1-1 gallon can of paint c. 2-quart containers of primer/paint d. 2-8 ounce cans of PVC (polyvinyl chloride) adhesive c. 2-4 ounce oz cans of PVC adhesive d. 1-4 ounce can purple PVC primer e. 1-12 oz can purple PVC primer B. On 08/15/18 at 12:08 pm, during an interview with the Operations Manager, he confirmed that: 1. The door to the electrical room was unlocked 2. The working clearance to the electric boxes was blocked by building supplies 3. Hazardous materials were stored in the electrical room: a. 4-5 gallon buckets of paint, b. 1-1 gallon can of paint c. 2-quart containers of primer/paint d. 2-8 ounce cans of PVC adhesive c. 2-4 ounce oz cans of PVC adhesive d. 1-4 ounce can purple PVC primer e. 1-12 oz can purple PVC primer	A 038	A038 The Facility will ensure the exterior electrical room is free of safety hazards and has a working clearance of 36" in front of the electrical panels. The Operations Manager will ensure that combustibles and flammable items are stored in approved locked metal cabinets in well ventilated areas. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	11/15/18

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	4037	A. BUILDING: _____ B. WING _____	09/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF WHITE ROCK	110 LONGVIEW DRIVE WHITE ROCK, NM 87544

(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 52	A 042		
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 Based on observation and interview, the facility failed to ensure that potentially hazardous exposed electrical wires and electrical plugs in the back yard were covered and maintained in a safe manner. This deficient practice has the potential for all 13 (R #1-13) residents listed on the census, provided by the Operations Manager on 09/15/18, to be at risk of harm, injury, or death from electrical shock. The findings are: A. On 9/15/18 at 11:59 am, during observation of the facility grounds a 4 x 4 pole with a gray electrical box attached in the back yard, the following was observed: 1. The front round cover of electric box missing with the cover laying on the ground.	A 042		

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	4037	A. BUILDING: _____ B. WING _____	08/17/2018

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A 042	Continued From page 53 2. Two electric plugs were exposed with the gray cover lying on the ground. 3. Coming up from the ground there is gray conduit, wrapped around the conduit (a tube used to protect and route electrical wiring in a building or structure) at the base of the gray box there were (3) electric cables with exposed wires sticking out. B. On 8/15/18 at 12:08 pm, during an interview with the Operations Manager, he confirmed that: 1. The front round cover of electric box missing with the cover laying on the ground. 2. Two electric plugs exposed with the gray cover lying on the ground. 3. Coming up from the ground there is gray conduit, wrapped around the conduit at the base of the gray box there were (3) electric cables with exposed wires sticking out.	A 042	A042 The Facility will ensure that potentially hazardous exposed electrical wires and electrical plugs are covered and maintained in a safe manner. The Operations Manager will ensure that the wires in electrical box attached in the back yard are properly covered. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	11/18/18
A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or	A 043		

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A 043	Continued From page 54 (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.43 Based on observation and interview, the facility failed to ensure that combustible materials were not stored in hazardous areas. This deficient practice has the potential for all 13 (R #1-13) residents on the census, provided by the Operations Manager on 08/15/18, to be at risk of harm, injury, or death if a fire were to occur. The findings are: Findings related to storage/electrical room A. On 08/15/18 at 11:55 pm, during an observation of the outside storage/electrical room containing the circuit breakers, cable TV and	A 043		

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A 043	Continued From page 55 telephone electrical wires, and boxes the following was observed: 1. The door was unlocked and accessible to residents. 2. 4-5 gallon buckets of paint 3. 1-1 gallon can of paint 4. 2-2 quart containers of primer/paint 5. 1-8 oz (ounce) cans of PVC (polyvinyl chloride) glue 6. 2-4 oz cans of PVC glue 7. 1-4 oz can purple primer 8. 1-12 oz can purple primer. B. On 08/15/18 at 12:08 pm, during an interview with the Operations Manager, he confirmed the the following combustible materials were being stored in the outside storage/electrical room next to the circuit breakers, cable TV, telephone, and electrical wires and boxes: 1. The door was unlocked and accessible to residents. 2. 4-5 gallon buckets of paint 3. 1-1 gallon can of paint 4. 2-2 quart containers of primer/paint 5. 1-8 oz cans of PVC glue 6. 2-4 oz cans of PVC glue 7. 1-4 oz can purple primer 8. 1-12 oz can purple primer. Findings related to electrical box C. On 8/15/18 at 11:59 am, during an observation of the facility grounds: 1. 4 x 4 pole with a gray electric box attached in the back yard 2. Front round cover of electric box missing 3. Two electric plugs exposed with the gray cover lying on the ground 4. Coming up from the ground there is gray conduit (a tube used to protect and route	A 043		

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A 043	Continued From page 56 electrical wiring in a building or structure), wrapped around the conduit at the base of the gray box there were (3) electric cables with exposed wires sticking out. D. On 8/15/18 at 12:12 pm, during an interview with the Operations Manager, he confirmed the observation of the the 4 x 4 pole with exposed potentially hazardous electrical wires and exposed electrical plugs. E. On 08/15/18 at 3:22 pm, during an observation of the attic, it was observed stored in the attic with the fuel fired (natural gas) furnace combustible materials: 1. 2-5 gallons of paint. 2. 2-1 gallons of paint. F. On 08/15/18 at 3:25 pm, during an interview with the Regional Administrator, she confirmed that combustible materials - paints were being stored in a hazardous area next to the fuel fired (natural gas) furnace.	A 043	A043 The Facility will ensure the exterior electrical room is free of safety hazards and has a working clearance of 36" in front of the electrical panels. The Operations Manager will ensure that combustibles and flammable items are stored in approved locked metal cabinets in well ventilated areas, and the area is secure from unauthorized entry. Current Staff will also be retrained regarding the proper storage and how to secure combustibles and Other flammable items. This training will be included in Employee Orientation for future staffers. The Administrator and/or Compliance Director will monitor continued compliance during quarterly in-house audits.	11/15/18