Approved 3/15/17

PRINTED: 12/02/2016
FORM APPROVED

attached 3/15/2017 DSG

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2036	A. BUILDING: _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF FARMINGTON #2	404 NORTH LOCKE ROAD FARMINGTON, NM 87401

(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 On 8/11/16, a Full-Onsite survey with 1 complaint intake NM#00030026 was conducted for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the survey. [redacted]	A 000		
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 (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12	A 016	RECEIVED FEB 27 2017 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU	

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B Ruzzell
TITLE: Administrator / RN
(X6) DATE: 120816

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A 016	Continued From page 1 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. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010]	A 016	7.8.2.16 B (3) (7) Pre-employment regulations have been addressed and are being followed. Documentation/proof of EAR is in all employee files. House managers will monitor employee files for documentation of pre-employment requirements monthly	091216

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A 016	Continued From page 2	A 016		

This REQUIREMENT is not met as evidenced by:
7.8.2.16 B (3) (7)

Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY

7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.
A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.
B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.
C. Applicant's identifying information required. In

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A 016	Continued From page 3	A 016		

making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry.

D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.

F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a

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A 016	Continued From page 4 directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these	A 016		

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A 016	Continued From page 5 rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with	A 016		

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A 016	Continued From page 6 the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility failed to ensure for 3 (DCS #s 1, 3 and 4) of 4 (DCS #s 1-4) Direct Care Staff files reviewed for compliance that the Employee Abuse Registry (EAR) were submitted before date of hire. This deficient practice has the potential for residents to be at risk of being provided care by caregivers that have a history of abuse, neglect, or exploitation and/or by convicted felons. The findings are: A. Record review of DCS #1's personnel file revealed that the EAR documentation was missing from the file.	A 016		

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A 016	Continued From page 7 B. Record review of DCS #3's personnel file revealed that the EAR documentation was missing from the file. C. Record review of DCS #4's personnel file revealed that the EAR documentation was missing from the file. D. On 08/10/16 at 11:45 am, in an interview with the Administrator, she confirmed that the EARs were not submitted for DCS #1, #3 and #4.	A 016		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights;	A 017	7.8.2.17 ABC All employees will recieve 16 hours of Supervised training, and 12 hours of annual training. 16 hours of training will be documented by manager and before providing unsupervised care. 1 hour of training will be done monthly for a total of 12 hours of annual training. House managers will provide training and document training. House manager will ensure documentation in binder - monthly inspection of all binders	092116

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A 017	Continued From page 8 (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7. 8.2.17 A B C Based on record review and interview the facility failed to ensure for 4 (S #s 1-4) of 4 (S #s 1-4) staff training files reviewed for compliance received the required: 1. 16-hours of supervised training 2. 12-hours of orientation and/or annual training. This deficient practice has the potential for all residents to be at risk of harm or injury if staff have not received training on the proper methods of providing care, and services. The findings are: A. Record review of S #1's (hire date 04/09/15), file revealed no documentation for: 1. 16-hours of supervised training. 2. Orientation training for: a. First Aid	A 017	(Cont) The following training will be provided by House managers and documented in all employee files: not limited to: · 1ST aid · fire safety · proper food storage · good personal hygeine · infection control · food preparation · emergency protocol · confidentiality · residents rights · quality resident care – ISP – 4 hour hospice training if appropriate.	092116

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A 017	Continued From page 9 b. Safe food handling c. Methods to provide quality resident care d. Implementation of Individual Service Plan (ISP) B. Record review of S #2's (hire date 09/04/12) file revealed no documentation for 16 hours of supervised training prior to providing unsupervised care for residents. C. Record review of S #3's (hire date 05/24/14) file revealed no documentation for : 1. 16-hours of supervised training. 2. Orientation training for: a. First Aid b. Safe food handling c. Confidentiality d. Residents rights e. Incident reporting f. Smoking Policy g. Quality residents care h. Emergency procedures i. Individual Service Plan (ISP) Implementation. 3. Annual training. D. Record review of S #4's (hire date 04/21/16) file revealed no documentation for: 1. 16-hours of supervised training. 2. Orientation training for: a. First aid b. Safe food handling c. Quality residents care d. Individual Service Plan (ISP) Implementation. E. On 08/10/16 at 11:45 am, during an interview with the Administrator, she confirmed that Staff #s	A 017	Employees will recieive 12 hours of annual and 12 hours of training of orientation.	

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A 017	Continued From page 10 1-4 have not received the required training's.	A 017		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the 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	A 020	7.8.2.20 A (12) (a) Beehive Homes has implemented a new admission including "The admission agreement may be terminated if an appropriate placement is found for the resident." All residents have been given this updated agreement and it is in their file. Upon admission the administrator will assure the updated agreement is in all residents binders In the updated agreement: • Staffing Ratio • 15 day written notice of discharge • Discharge reasons - medical / mental deterioration - Resident Refusal to comply with policies - facility closes - facility cannot meet needs	090116

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A 020	Continued From page 11 surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections;	A 020	(Cont'd) 090116 7.8.2.20 A (12) (a) - - mutual agreement between both parties) -30 day notice (written) will be given for: - change of cost - new amended admission agreement - House manager & administrator to assure all binders have correct documentation - Monthly monitoring to be done by house manager on all binders.	

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A 020	Continued From page 12 (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such	A 020		

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	2035	A. BUILDING: _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 020	Continued From page 13 needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (12) (a)	A 020		

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	2036	A. BUILDING: _____ B. WING _____	C 08/11/2016

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A 020	Continued From page 14 Based on record review and interview, the facility failed to ensure that 4 (R #'s 1 - 4) of 4 (R #'s 1 - 4) residents reviewed for admission/discharge agreements, included the following: 1. The facility's staffing ratio. 2. The statement an "appropriate placement" is found for the resident if the agreement should be terminated. 3. 15-day written notice for non-payment of rent. 4. Information that a 30-day notice would be provided prior to any changes in care or costs being implemented. This deficient practice has the potential for all residents to be at risk of harm if the admission/discharge agreement is terminated without a place for residents to transfer to and without written notice, being charged for new/changed care services without the appropriate 30-day notice, and unaware of the amount of staff available for care and services. The findings are: A. Record review of R #1's Admission Agreement dated 08/27/15, revealed the following: 1. The staffing ratio was not stated in the agreement. 2. The admission agreement did not include " If an appropriate placement was found." 3. The admission agreement inaccurately stated for non payment of rent an immediate or emergency transfer would be necessary without written or thirty (30) day notice. 4. The admission agreement did not state that the facility will provide a thirty (30) day written notice to residents regarding any changes in the cost or material services provided. B. Record review of R #2's Admission Agreement	A 020		

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A 020	Continued From page 15	A 020		

dated 12/15/14, revealed:
1. The admission agreement did not include "If an appropriate placement was found."
2. The admission agreement inaccurately stated for non payment of rent an immediate or emergency transfer would be necessary without written or thirty (30) day notice.

3. The admission agreement did not state that the facility will provide a thirty (30) day written notice to residents regarding any changes in the cost or material services provided.

C. Record review of R #3's Admission Agreement dated 9/13/13, revealed:
1. The admission agreement did not include " If an appropriate placement was found."
2. The facility will provide a thirty (30) day written notice to residents regarding any changes in the cost or material services provided was included in the Admission Agreement.
3. The admissions agreement did not state that the facility will provide a thirty (30) day written notice to residents regarding any changes in the cost or material services provided.

D. Record review of R #4's Admission Agreement dated 6/01/15, revealed:
1. The admission agreement did not include " If an appropriate placement was found."
2. The facility will provide a thirty (30) day written notice to residents regarding any changes in the cost or material services provided was included in the Admission Agreement.
3. The admissions agreement did not state that the facility will provide a thirty (30) day written notice to residents regarding any changes in the cost or material services provided.

E. On 08/09/16 at 1:40 am, during interview the

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A 020	Continued From page 16 Administrator confirmed that the Admission Agreements did not include: the staffing ratio, the statement "if an appropriate placement is found", the facility will provide a thirty day (30) written noticed to residents regarding any changes in the cost or material services provided. The admission agreements inaccurately stated for nonpayment of rent an immediate or emergency transfer would be necessary without written or thirty (30) day notice.	A 020		
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;	A 025		

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A 025	Continued From page 17 (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A B C D E Based on record review and interview the facility	A 025	7.8.2.25 ABCDE Resident evaluations will be completed at least 15 days of admission to determine baseline. Evaluations and ISP to be completed and documented every 6 months by RN/LPN. RN/LPN to check all resident files monthly to ensure this is implemented. All residents evaluations and ISP are current and documented /regulations.	091216

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A 025	Continued From page 18 failed to ensure that 4 (R #'s 1-4) of 4 (R #'s 1-4) residents whose evaluations were reviewed for compliance were: 1. Signed by a license practical nurse (LPN), registered nurse (RN) or physician's extender (PE). 2. Completed within 15 days prior to admission. 3. Reviewed at a minimum of every 6 months or when there is a significant change in the resident's health status. This deficient practice could result in a delay in care, services, and assistance the residents may need due to a change in condition, resulting in possible complications and the need for medical intervention. The findings are A. Record review of R #1's file Resident Evaluation dated 09/15/15 and 06/08/16, revealed evaluations were not reviewed at six months. B. Record review of R #2's Evaluation revealed evaluation dated 01/19/16, was not completed 15-days prior to admitting date of 12/15/14, and not signed by a LPN, RN, or PE. Evaluations have not been reviewed or up-dated since. C. Record review of R #3's evaluation dated December 2013, revealed it was not completed 15-days prior to admitting date of 09/13/13, or signed or reviewed by a LPN, RN, or PE. Evaluation dated 02/09/16, was not signed or reviewed by a LPN, RN, PE. There were no evaluations reviewed between December 2013 and 02/09/16. D. Record review of R #4's evaluation dated 06/09/15, was not completed 15-days prior to admitting date of 06/01/15, and no evaluations	A 025		

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A 025	Continued From page 19 have been reviewed or up-dated since. E. On 08/09/16 at 1:40 pm, during interview, the Administrator confirmed that the residents' evaluations were completed late, not signed, and not reviewed every six months by an LPN, RN or a PE.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided;	A 026	7.8.2.26 A (2) (3) Evaluations and ISP now complete and currently upto date and documented in all residents files. RN/LPN and house manager to update ISP every 6mo or sooner if sig. change. RN/LPN and House manager to monitor this in all resident files monthly	091216

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A 026	Continued From page 20 (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (2) (3) 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 Individual Service Plans (ISPs) were reviewed for compliance were current, reviewed and signed by a nurse or physicians extender. This deficient practice has the potential for the residents not to receive the appropriate care and assistance they need as changes in their health status occurs. The findings are: A. Record review of R #1's file revealed the ISP dated 10/21/15, was not completed within 10-days of the admission date of 08/27/15, was not signed, and was not reviewed at a minimum of every six months or when there is a significant change in the resident's health status. B. Record review of R #2's file revealed the ISP dated 01/22/15, was not completed within 10-days of the admission date of 12/15/16, was not signed and was not reviewed at a minimum of	A 026		

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A 026	Continued From page 21 every six months or when there is a significant change in the resident's health status. C. Record review of R #3's file revealed the ISP dated 01/19/15, was not completed within the 10-days of the admission date of 09/13/13, and not reviewed at a minimum of every six months or when there is a significant change in the resident's health status. D. Record review of R #4's file revealed the ISP dated 11/11/15, was not completed within the 10-days of the admission date of 08/01/15. E. On 08/09/16 at 1:40 pm, during an interview with the Administrator, she confirmed that R #'s 1-4 were not in compliance with ISPs being completed within 10-days of admission, reviewed at a minimum of every six months or when there is a significant change in the resident's health.	A 026		
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	A 034		

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A 034	Continued From page 22 in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to 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;	A 034		

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A 034	Continued From page 23 (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 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	A 034		

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A 034	Continued From page 24 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) Reference NFPA 99, 1999 Edition Section 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity, In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage	A 034	7.8.2.34 A (7) Proper per regulation medical gas cylinder storage cabinet with 1 hour fireproof & ventilation provided for home. Cabinet stands alone and used only for oxygen cylinders. Cabinet not in residents rooms.	120116

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	2035	A. BUILDING: _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF FARMINGTON #2	404 NORTH LOCKE ROAD FARMINGTON, NM 87401

(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 034	Continued From page 25 locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7]. 6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. 7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)]. Based on observation and interview, the facility failed to ensure that oxygen cylinder tanks were stored securely. This deficient practice has the potential for all 11 (R #1-11) residents on the census provided by the Administrator on 08/09/16, to be at risk of harm or death if the oxygen cylinder tanks were to fall over damaging the valve, causing it to depressurize. The findings are:	A 034	House manager and maintenance staff will monitor on a monthly basis that O2 tanks are not on residents rooms and are stored in approved fireproof cabinet to remain in compliance.	

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A 034	Continued From page 28 A. Observation of resident room #5 revealed 12 oxygen cylinder tanks in a crate stored in the room. B. Observation of resident room #12, revealed 6 oxygen cylinder tanks in a crate stored in their room. C. On 08/08/16 at 3:45 pm, during an interview with Staff (S) #4, she stated that oxygen cylinder tanks were stored in living areas of residents' rooms #5 and #12.	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications	A 035		

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A 035	Continued From page 27 shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include:	A 035		

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A 035	Continued From page 28 (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 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	A 035		

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A 035	Continued From page 29 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 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: Based on observation and interview, the facility	A 035	7.8.2.35 Staff to assist residents with non invasive meds. Blood glucose monitoring via finger sticks to be provided by RN/LPN. House manager, RN/LPN to monitor daily or as needed per doctors orders.	091216

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A 035	Continued From page 30 failed to ensure that only a licensed nurse or certified healthcare professional conduct an invasive procedure for 1 (R #5) of 2 (R #s 1 and 5) residents whose medication pass were observed for compliance. This deficient practice has the potential for the residents to be at risk of harm or death if invasive procedures are performed by non-licensed direct care staff (DCS) who don't understand the seriousness of the procedure. The findings are: A. During a medication pass observation on 08/10/16 at 7:35 am, Staff (S) #5 was observed doing a finger stick (blood draw) with R #5. B. On 08/10/16, at 9:00 am, during interview with the Administrator, she confirmed that S #5 administered a blood sugar check on R #5.	A 035		
A 045	7 NMAC 8.2.45 Water WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC. A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations. B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non-community water system as defined by the current New Mexico drinking water requirements. C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented	A 045		

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A 045	Continued From page 31 from entering potable water systems by appropriate cross connection and backflow prevention devices. D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries. E. The hot water temperature that is accessible to residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury. [7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.45 E Based on observation and interview, the facility failed to ensure that the hot water temperatures were maintained within the range of 95 degrees Fahrenheit (F) and 110 degrees F. This deficient practice has the potential for all 11 (R #s 1-11) residents identified on the census provided by the Administrator on 08/09/16, who are able to use their own bathrooms to be at risk of injury from scalding hot water. A. On 08/10/16 at 8:00 am, during observation of resident room #4, the hot water temperature from the sink faucet in the bathroom was 122 degrees F.	A 045	7.8.2.45 E Water temp in all residents rooms/ bathroom sink, showers now measure between 95°F - 110°F. House manager and maintenance staff to monitor water temperatures weekly.	091216

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A 045	Continued From page 32 B. On 08/10/16 at 8:05 am, during observation of resident room #1, the hot water temperature from the sink faucet in the bathroom was at 111 degrees F. C. On 08/10/16 at 8:10 am, during observation of the community bathroom the hot water temperature from the sink faucet was at 111 degrees F. D. On 08/10/16 at 8:16 am, during interview with staff (S) #5, she confirmed that the water temperatures were in excess of the safe and required temperatures of 95 degrees to 110 degrees F.	A 045		
A 048	7 NMAC 8.2.48 Electrical System ELECTRICAL SYSTEM: A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility shall know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances shall be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords shall not be used. The use of a multi-socket united laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) feet in length is permitted for the intended purpose and not as an extension cord. [7.8.2.48 NMAC - Rp, 7.8.2.49 NMAC, 01/15/2010]	A 048		

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A 048	Continued From page 33 This REQUIREMENT is not met as evidenced by: 7.8.2.48 C (2) NFPA 70 National Electric Code 210.8 Ground Fault Circuit Interrupter Protection for Personnel 210.8 (B) Other than dwelling units. All 125 volt, single phase, 15 and 20 ampere receptacles installed in the locations specified in 210.8 (B)(1) through (8) shall have ground fault circuit interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception 1: to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow melting, de-icing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22 as applicable. Exception 2: to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B) (2)shall be permitted for only those receptacles outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 6 ft. of the outside edge of the sink. Exception 1 to (5): In industrial laboratories, receptacles used to supply equipment where	A 048	7.8.2.48 C (2) Circuit Breakers are labeled correctly. Maintenance staff will maintain labels. All extension cords are removed and not to be used. GFCI outlets have now been installed in all wet locations. Maintenance staff will monitor weekly to ensure compliance.	120216

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A 048	Continued From page 34 removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. 314.25: Covers and Canopies. In completed installations, each box shall have a cover, faceplate, lampholder, or luminaire canopy, except where the installation complies with 410.24(B) 406.5(F): Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. Based on observation and interview, the facility failed to ensure Ground Fault Circuit Interrupter (GFCI) outlets were used within 6 feet of water source. This failed practice has the potential to for all 11 (R #'s 1-11) residents identified on the resident census provided by the administrator on 08/09/16, to be at risk of injury or death due to electric shock. The findings are: A. On 08/08/16 at 8:50 am, during observation of the laundry room, the washing machine was plugged into a non-GFCI outlet measured to be	A 048		

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A 048	Continued From page 35 located within a 6 feet of a water source. B. On 08/08/16 at 9:45 am, during an interview with the Administrator, she confirmed that the washing machine was plugged into a non-GFCI outlet located within 6 feet of the machine.	A 048		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Based on observation and interview the facility failed to ensure that 4 of 5 fire extinguishers had been inspected monthly as recommended by the	A 063		

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A 063	Continued From page 38 manufacturers to ensure proper working order in case of fire. This deficient practice has the potential for all 11 (R #'s 1-11) residents on the census provided by the Administrator on 08/09/16, to be at risk of injury or death if there is a fire and the fire extinguisher does not work properly. The findings are: A. On 08/08/16 at 3:15 pm, during observation, the fire extinguisher next to the back exit of the facility revealed that it had not been inspected since October 2015. B. On 08/08/16 at 3:20 pm, during observation, the fire extinguisher next to the office revealed that it had not been inspected since October 2015. C. On 08/08/16 at 3:25 pm, during observation, the fire extinguisher next to resident room #3, revealed that it had not been inspected since October 2015. D. On 08/08/16 at 3:30 pm, during observation, the fire extinguisher next to resident room #6 revealed that it had not been inspected since October 2015. E. On 08/09/16 at 10:39 am, during an interview with the Administrator, she confirmed that the four (4) fire extinguishers have not been inspected since October 2015.	A 063	7.8.2.6.3 B All fire extinguishers inspected for: - tags present - lock tie intact - guage in green area - not expired Inspection is done monthly and signed off on tag of inspection. Maintenance & House manger to inspect monthly.	091216
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and	A 070		

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A 070	Continued From page 37 standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.70 D E Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and	A 070		

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Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2035	A. BUILDING: _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF FARMINGTON #2	404 NORTH LOCKE ROAD FARMINGTON, NM 87401

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A 070	Continued From page 38	A 070	7.8.2.7D DE Employee Abuse Registry Screening is ran before hire. Documentation is in all employee binders. Drivers license / State ID and S.S. card is copied and in employee binder for Caregiver Criminal History Screening. House manager to inspect all files monthly to ensure compliance.	091216

updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.
A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.
B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.
C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry.
D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.
E. Documentation for other staff. With respect to all employed or contracted individuals providing

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A 070	Continued From page 39	A 070		

direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.
F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.
[7.1.12.8 NMAC - N, 01/01/2006]

7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:
. . .

D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department.
(1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC.
(2) A signed authorization for release of

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A 070	Continued From page 40	A 070		

information form.
(3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink.
(4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the Federal Bureau of Investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department.
. . .

E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant ,

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A 070	Continued From page 41	A 070		

caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by department of public safety and the federal bureau of investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules.
The fees will not be applied to any other activity or expense undertaken by the department.
F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.
G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules.
(1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification.
(2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes.

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A 070	Continued From page 42 Based on record review and interview the facility failed to ensure for 3 (DCS #'s 1, 3 and 4) of 4 (DCS #'s 1-4) Direct Care Staff files reviewed for compliance that the EARs were submitted before date of hire. This deficient practice has the potential for the residents to be at risk of being provided care by caregivers that have a history of abuse, neglect, or exploitation and/or by convicted felons. The findings are: A. Record review of DCS #1's revealed that the EAR documentation was missing from the file. B. Record review of DCS #3's revealed that the EAR documentation was missing from the file. C. Record review of DCS #4's revealed that the EAR documentation was missing from the file. D. On 08/10/16 at 11:45 am, in an interview with the Administrator she confirmed that the EARs were not submitted for DCS #1, #3 and #4.	A 070		

BeeHive
HOMES

Quality Senior Living
In A Residential Setting

404 N. Locke Ave. Farmington, NM 87401

To: Alanna Curley/Sarah Miller
Attn: _____
Fax: 505-476-9048
Re: Plan of Correction(3)

From: Bernadette Cruz Administrator
Phone: 505-325-1355
Fax: 505-325-1779
Date: 2/23/17

Concerns:

License# 2035

NEW MEXICO DEPARTMENT OF HEALTH

SUSANA MARTINEZ, GOVERNOR

LYNN GALLAGHER, SECRETARY DESIGNATE

February 21, 2017

Bernadette Cruz, Administrator
Beehive Homes Of Farmington #2
404 North Locke Road
Farmington, NM 87401

License # 2035

IMPORTANT NOTICE - PLEASE READ IMMEDIATELY

Dear Ms. Cruz:

On August 11, 2016, a Complaint survey was conducted at Beehive Homes Of Farmington #2 by the Department of Health (DOH) to determine if your facility was in compliance with the New Mexico State Requirements for Assisted Living Facilities for Adults. This survey found that your facility was not in substantial compliance with the participation requirements. Refer to the State Agency Enforcement Notice dated December 2, 2016.

On December 20, 2016, the Plan of Correction (PoC) for the deficiencies cited on the August 11, 2016, Complaint survey were reviewed. The PoCs for the following deficiencies were rejected due to the fact they did not meet the required criteria:

1: AO17-How the facility will ensure that staff receive the required trainings at orientation and annually. Include all required trainings in the POC.

2. AO20-How the facility identified and corrected the Admission Agreements for other residents affected by the deficient practice. How and who (position) will monitor to ensure on-going compliance.

3: AO25, AO26-How the facility identified and corrected the Evaluations and Individual Service Plans for current residents affected by the deficient practice.

4: AO34-If the new oxygen storage cabinet is ventilated.

5: AO48-How and who (position) will monitor for continued compliance.

Plan of Correction (PoC)

Your PoC for the deficiencies listed on the State Form must be submitted within three (3) business days from your receipt of this form. Failure to submit an acceptable PoC may result in sanctions, including but not limited to civil monetary penalties, suspension or non-renewal of the facility license [NMAC 7.8.2.12(B)(5)]. Include a completion date for each deficiency cited. Your PoC shall:

1. Address how all violations identified in the official statement of deficiencies will be corrected;

2. Address how the facility will monitor the corrective action and ensure ongoing compliance; and

3. Specify the date that the corrective action will be completed.

Please submit your PoC under the appropriate column on the enclosed CMS-2567. Address each deficiency and include the month, date and year of the expected completion date. **Sign, date, and indicate your title in the appropriate blocks on page 1 of the form.** Return the CMS-2567 with the PoCs to the DOH via fax, email or mail to the attention of:

Sarah Miller, Reviewer
2040 S. Pacheco St. 2nd Floor Room 202
Santa Fe, NM 87505
Phone: (505) 476-9031
Fax: (505) 476-9048
HFLC.Review@state.nm.us

The State Form must be printed as it was sent to you and put your PoCs on the original State Form. You are not permitted to alter the State Form in any way.

If you have any questions regarding this process, please contact me at (505) 476-9070.

Sincerely,

Rhonda Rodriguez
Long Term Care Program Manager
Program Operation Bureau

Attachments: August 11, 2016, 3rd Set State Form