

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2225	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/14/2016
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NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF EDGEWOOD II	STREET ADDRESS, CITY, STATE, ZIP CODE 102 B QUAIL TRAIL EDGEWOOD, NM 87015
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A 000	Initial Comments The following deficiencies were cited as a result of a Full-Onsite survey conducted on 01/14/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. One complaint # NM 29847 was substantiated with deficiencies cited.	A 000	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by New Mexico state law. A008 How all violations identified in the official statement of deficiencies will be corrected: The facility license is now posted immediately inside the facility entrance in a common area where all residents, visitors, and staff can see it. How the facility will monitor the corrective action and ensure ongoing compliance: The facility administrator will assure that the facility license is maintained in a visible public area where it can be seen by all.	01/15/16
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	A 008		

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

STATE FORM

6829

L20S11

TITLE
RECEIVED

(X6) DATE

7/8/16

JUL 11 2016

HEALTH FACILITY LICENSING
& CERTIFICATION BUREAU

Continuation sheet 1 of 62

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2225	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/14/2016
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEE HIVE HOMES OF EDGEWOOD II

**102 B QUAIL TRAIL
EDGEWOOD, NM 87015**

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A 008	Continued From page 1 information shall be submitted to the licensing authority for approval: (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	A 008		

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A 008	Continued From page 2 that have at least five percent (5%) ownership interest in the facility, whether direct or indirect 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.	A 008			

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A 008	Continued From page 3 (2) An application for increase in capacity shall be accompanied by a building plan pursuant to 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	A 008			

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A 008	Continued From page 4 licensing authority at least thirty (30) calendar days prior to the closure. 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	A 008			

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A 008	Continued From page 5 opens or maintains an assisted living facility without a license is subject to the imposition of 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: Based on observation and interview the facility failed ensure that the facility license was displayed in a conspicuous place where all 11 (R #1-11) residents currently residing in the facility, visitors, and staff can see it. If the facility license is not displayed in a conspicuous place then the residents, visitors, and staff will not know if the facility has and/or is maintaining a current license as an Assisted Living Facility. The findings are: A. On 01/12/16 at 2:10 pm, during observation the facility license was not posted in a conspicuous place where residents, visitors, and staff could see it. It was observed to be posted in	A 008			

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A 008	Continued From page 6 the nursing office in the back of the medication room. B. On 01/14/16 at 3:25 pm, during interview with the Administrator, she confirmed that the facility license is not posted in a conspicuous place where residents, visitors, and staff can see it.	A 008		
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 NMAC.	A 016		

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A 016	Continued From page 7 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		

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A 016	Continued From page 8 This REQUIREMENT is not met as evidenced by: 7.8.2.16 B (3) (6) 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 making the inquiry to the registry prior to	A 016		

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A 016	Continued From page 9 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 directed plan of correction, civil monetary penalty	A 016			

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A 016	Continued From page 10 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 11 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		

PRINTED: 06/28/2016
FORM APPROVED

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STREET ADDRESS, CITY, STATE, ZIP CODE

BEE HIVE HOMES OF EDGEWOOD II

102 S QUAIL TRAIL
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A 016	Continued From page 12 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 that Caregivers (CG) met the Employee Abuse Registry (EAR) and the Caregivers Criminal History Screening (CCHSP) Requirements for 6 Caregivers (CG #s 2, 5, 7, 8, 10 and 12) of 7 (CG #s 2, 5, 7, 8, 10, 11 and 12) employee files reviewed for compliance. This deficient practice has the potential for residents to be at risk for harm, abuse, neglect or exploitation if the facility is not completing the EAR and/or CCHSP screening on caregivers prior to their date of hire. The findings are: A. Record review of CG #2's employee file reveals a hire date of 07/02/14 and the (CCHSP) Person Summary indicates the EAR was checked 4 days later on 07/06/14.	A 016		

Division of Health Improvement
STATE FORM

6495

L20S11

If continuation sheet 13 of 6

PRINTED: 06/28/2016
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2225	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/14/2016
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF EDGEWOOD II		STREET ADDRESS, CITY, STATE, ZIP CODE 102 B QUAIL TRAIL EDGEWOOD, NM 87015			
(X4) JD 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 016	Continued From page 13 B. Record review of CG #5's employee file reveals a hire date of 09/04/14 and the (CCHSP) Person Summary indicates the EAR was checked 5 days later on 09/09/14. C. Record review of CG #7's employee file reveals a hire date of 01/04/16 and the (CCHSP) Person Summary indicates the EAR was checked 1 days later on 01/05/16. D. Record review of CG #8's employee file reveals a hire date of 01/06/16 and the (CCHSP) Person Summary indicates the EAR was checked 1 days later on 01/07/16. E. Record review of CG #10's employee file revealed a hire date of 11/11/15 and no documentation available that indicates when her EAR clearance application or her fingerprints were submitted to the CCHSP. F. Record review of CG #12's employee file revealed a hire date of 09/05/15 and that her EAR clearance application was not submitted until 09/11/16, 6-days after being hired. G. On 01/12/16 at 9:00 am, during interview with the Administrator, she confirmed the EAR and CCHSP screenings were not completed as required for CG #2, 5, 7, 8, 10, and 12. H. On 02/12/16 at 11:07 am, during interview with [name of director] of the CCHSP program, reported that R #10's EAR application was not received until 11/12/15, 1-day after she was hired. Her fingerprints were not submitted within 20-days resulting in her file being closed. A new	A 016	A016 <i>How all violations identified in the official statement of deficiencies will be corrected:</i> All subsequent newly employed direct care staff will be screened through the Employee Abuse Registry prior to the first day of employment. All subsequent newly employed direct care staff will also have their fingerprints submitted to the CCHSP no later than 20 days from the first day of employment. <i>How the facility will monitor the corrective action and ensure ongoing compliance:</i> The facility administrator will monitor for compliance on all new direct care staff hires by means of a new hire checklist, which will be in place in the personnel file for each direct care staff member.	07/05/15 07/05/16	

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STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2225	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/14/2016
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A 016	Continued From page 14 EAR clearance application was received on 12/09/15 and her fingerprints for her CCHSP clearance were not received until 12/17/15, 36-days after she was hired.	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; (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	A 017		

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A 017	Continued From page 15 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: Citation Text for Tag 0017, Regulation 5Q7U 7.8.2.17 B, C Based on record review and interview, the facility failed to ensure that staff receive 16 hours of supervised training prior to providing unsupervised care for residents for 4 (CG #s 4, 5, 7 and 8) of 4 (CG #s 4, 5, 7 and 8) caregivers records reviewed for training. This deficient practice has the potential for residents to be at risk of harm or injury if the Direct Care Staff (DCS) providing their care have not received the required supervised training, before providing resident care. The findings are: A. Record review of CG #4's personnel file (hire date 12/17/13) revealed no documentation that she received 16 hours of supervised training prior to providing unsupervised care to residents. B. Record review of CG #5's personnel file (hire date 09/14/14) revealed no documentation that she received 16 hours of supervised training prior to providing unsupervised care to residents.	A 017	A017 <i>How all violations identified in the official statement of deficiencies will be corrected:</i> All newly hired direct care staff will complete 16 hours of supervised training prior to providing unsupervised care. This training will be part of the new hire orientation process and will be documented in the employee's personnel file. <i>How the facility will monitor the corrective action and ensure ongoing compliance:</i> The facility administrator will monitor for compliance by reviewing the employee file of each new hire and by verifying this training is scheduled for each new caregiver, with the house manager.	07/05/16	

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A 017	Continued From page 16 C. Record review of CG #7's personnel file (hire date 01/04/16) revealed no documentation that she received 16 hours of supervised training prior to providing unsupervised care to residents. D. Record review of CG #8's personnel file (hire date 01/06/16) revealed no documentation that she received 16 hours of supervised training prior to providing unsupervised care to residents. E. On 01/12/16 at 8:30 am, during an interview with the Administrator, she confirmed the new hires first shift is completing all the required paperwork for new hired employees. Then they shadow another employee for 2 shifts before working a shift on their own. Once the new employee is entered into the computerized training program the House Manager gives the new employee their training schedule and the employee takes the online trainings according to the dates provided by the House Manager.	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;	A 020		

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A 020	Continued From page 17 (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; (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	A 020			

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A 020	Continued From page 18 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 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	A 020		

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A 020	Continued From page 19 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 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	A 020			

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A 020	Continued From page 20 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: Based on record review and interview the facility failed to ensure that: 1. A team meeting was held prior to admitting or retaining a resident who has elected to receive hospice services. 2 Team meeting approval is in writing, signed, and dated by all team members and the approval is maintained in the residents record. 3. Resident Individual Service Plans (ISPs) are updated to reflect the coordination of care between the facility and the hospice provider, for 4 (R #s 1, 4, 5, and 1) of 4 (R #s 1, 4, 5, and 11) residents identified as receiving hospice services from an outside provider. This deficient practice has the potential to affect the health and safety of the residents due to direct care staff not knowing and understanding the specific needs of the residents and not knowing what services the hospice agency is providing. The findings are:	A 020		

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A 020	Continued From page 21 Findings related to team meetings. A. Record review of resident charts for residents receiving hospice services revealed that: 1. R #4's resident chart did not include admission date to hospice, and no documentation that an Admission/Retention Exemption team meeting occurred including team approval of appropriate placement in writing and retained by the facility. 2. R #5's resident chart did not include admission date to hospice and and no documentation that an Admission/Retention Exemption team meeting occurred including team approval of appropriate placement in writing and retained by the facility. 3. R #11's resident chart did not include admission date to hospice and and no documentation that an Admission/Retention Exemption team meeting occurred including team approval of appropriate placement in writing and retained by the facility. B. On 01/12/16 at 10:25 am, during interview with the House Manager, she: 1. Confirmed the findings for R #4 and stated that they did have a team meeting, but they can not find the paperwork. 2. Confirmed the findings for R #5 and stated the chart may have been thinned. She says the team meeting did occur, but they cannot find the paperwork. 3. Confirmed the findings for R #11 and stated that the team meeting is scheduled for tomorrow 01/13/16. Findings related to ISP's and coordination of care. C. Record review of R #s 1, 4, 5, and 11 ISP's revealed no documentation of coordination of	A 020	A020 <i>How all violations identified in the official statement of deficiencies will be corrected:</i> A team meeting will be held for each resident currently on hospice services to document the team's decision to retain the resident in the facility. For all new hospice residents, such team meeting will be held prior to the resident being admitted to the facility or prior to the beginning of hospice services. The team meeting will be documented in writing and a copy of the team's approval will be kept in the resident's record. The Individual Service Plan (ISP) for each hospice resident will contain evidence of care coordination for all services provided by the hospice agency. This evidence will consist of the ISP being reviewed and signed by facility and hospice representatives. <i>How the facility will monitor the corrective action and ensure ongoing compliance:</i> The facility administrator will review the record of each resident receiving hospice services to verify that the team meeting has been held and documented, and that there is evidence of care coordination with the hospice agency.	07/15/16

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A 020	Continued From page 22 care with the hospice providers. D. On 01/12/16 at 10:25 am, during interview with the House Manager, she confirmed that R #s 1, 4, 5, and 11) ISP's do not include documentation of coordination of care with the hospice providers.	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; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being;	A 025		

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A 025	Continued From page 23 (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: Based on record review and interview, the facility failed to ensure resident evaluations were completed within 15 days prior to admission and reviewed at a minimum of every 6 months, or when there is a change in the residents condition for 4 (R #s 1, 4, 5 and 12) of 5 (R #s 1, 4, 5, 11	A 025			

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A 025	Continued From page 24 and 12) residents whose evaluations were reviewed for compliance. This deficient practice could result in a delay in care, services, and assistance the residents need resulting in possible complications and the need for medical intervention. The findings are: A. Record review of R #1's (admission date 12/26/13) evaluations revealed an initial evaluation dated 12/30/13, 4 days after admission. There were no additional reviewed or updated evaluations for R #1. B. On 01/12/16 at 10:25 am, during interview with the House Manager, she confirmed that the initial evaluation was not completed until 4 days after R#1 was admitted and that R #1's evaluations had not been reviewed and updated since. C. Record review of R #4's evaluations revealed that his evaluations had not been reviewed or updated every 6 months as required from 10/10/14 to 01/05/16. D. On 01/12/16 at 10:25 am, during interview with the House Manager, she confirmed that R #4's evaluations had not been reviewed or updated between 10/10/14 to 01/05/16. E. Record review of R #5's evaluations revealed that her last evaluation was dated 05/22/13 and had not been reviewed or updated since. F. On 01/12/16 at 10:25 am, during interview with the House Manager, she confirmed that R #5's evaluations had not been reviewed and updated since 05/22/13. G. Record review of R #12's evaluations	A 025	A025 <i>How all violations identified in the official statement of deficiencies will be corrected:</i> An evaluation to determine appropriateness of placement will be conducted within 15 days prior to admission, for all residents newly admitted to the facility. In addition, all resident evaluations for current and new residents will be reviewed at least every 6 months or whenever there is a significant change in the resident's condition. <i>How the facility will monitor the corrective action and ensure ongoing compliance:</i> An initial resident evaluation will be completed and placed in each new resident's record. This evaluation will be reviewed with the resident or their decision maker as part of the admission process. A schedule will be maintained that will show due dates of every 6 month reviews, and the house manager will coordinate these reviews with the facility's contracted nurse.	07/05/16

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A 025	Continued From page 25 revealed that her last evaluation was dated 01/10/14. H. On 01/12/16 at 10:25 am, during interview with the House Manager, she confirmed that R #12's evaluations had not been reviewed and updated since 01/10/14. 7.8.2. 25 A, B I. Record review of R # 10's Resident Evaluations revealed there was no resident evaluation completed prior to R #10's re-admission to the facility following a hospitalization for a fractured right hip. J. On 11/14/16 at 1:20 pm am during interview with the Administrator, she confirmed that there was no resident evaluation completed prior to R #10's re-admission to the facility following the fractured right hip.	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.	A 026			

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A 026	Continued From page 26 (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.26 A, B	A 026		

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A 026	Continued From page 27 Based on record review and interview the facility failed to ensure that the Individual Service Plans (ISP) for 6 (R #1, 4, 5, 10, 11 and 12) of 6 (R #s 1, 4, 5, 10, 11 and 12) residents whose Individual Service Plans (ISP's) were reviewed for compliance: 1. Were completed within 10 days of admission. 2. Included documentation of services to be provided by an outside agency. 3. Were reviewed at a minimum of every 6 months or when there is a change in condition. 4. Have documented expected goals and outcomes. If ISP's are not complete, accurate, and reviewed at a minimum of every 6 months then the caregivers will not know what what care to provide or what goals the resident needs to achieve to maintain the highest level of mental or physical well-being. The findings are: A. Record review of R #1's ISPs dated 01/07/14 and 01/14/15 revealed that: 1. R #1's ISP was not reviewed and updated every 6 months. 2. R #1's ISP did not include documentation of services to be provided by an outside agency. 3. R #1's ISP did not include any expected goals or outcomes. B. Record review of R #4's most current ISP dated 01/14/15 revealed: 1. R #4's ISP was not reviewed and updated every 6 months. 2. R #4's ISP did not include documentation of services to be provided by an outside agency. 3. R #4's ISP did not include any expected goals or outcomes. C. Record review of R #5's ISPs dated 05/20/13,	A 026	A026 How all violations identified in the official statement of deficiencies will be corrected: Individual Service Plan (ISP) for each resident will be reviewed and revised as necessary, at least every 6 months or upon a significant change in the resident's condition. Any services provided by an outside agency will be listed in the ISP. The ISPs for current residents have been updated to include expected goals and outcomes. ISPs for all new residents will also include expected goals and outcomes. How the facility will monitor the corrective action and ensure ongoing compliance: The facility administrator will audit each resident's record monthly to verify that the service plans are current, reflect any services provided by outside agencies, and include goals and outcomes.	07/15/16	

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A 026	Continued From page 28 02/27/14 and 01/14/15 revealed that: 1. R #5's ISP's were not reviewed and updated every 6 months. 2. R #5's ISP did not include documentation of services to be provided by an outside agency. 3. R #5's ISP did not include any expected goals or outcomes. D. Record review of R # 11's ISP dated 12/25/15 revealed that: 1. R# 11's ISP was not reviewed and updated every 6 months. 2. R #11's ISP did not include documentation of services to be provided by an outside agency. 3. R #11's ISP did not include any expected goals or outcomes. E. Record review of R #12's ISP dated 01/14/15 revealed that: 1. R #12's ISP was not reviewed and updated every 6 months. 2. R #12's ISP did not include documentation of services to be provided by an outside agency. 3. R #12's ISP did not include any expected goals or outcomes. F. On 01/11/16 at 2:45 pm, during interview with the Administrator, she confirmed the above ISP findings for R #1, 4, 5, 11 and 12. The Administrator stated that she thought they only had to be reviewed annually. G. On 01/12/16 at 10:25 am, during interview with the House Manager, she confirmed that the ISPs were not reviewed and updated every 6 months and/or did not include documentation of services to be provided by an outside agency for R #s 1, 4, 5, 11 and 12.	A 026		

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A 026	Continued From page 29 H. Record review of R # 10's medical record revealed no revision or update to the resident evaluation was completed prior to R #10's re-admission to the facility following a hospitalization for a fractured right hip on 10/06/15. I. On 11/14/16 at 1:20 pm, during interview with the owner, she confirmed that there was no resident evaluation completed prior to R # 10's re-admission to the facility following the fractured right hip on 10/06/15.	A 026		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant 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	A 033		

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A 033	Continued From page 30 or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident's medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (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;	A 033		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEE HIVE HOMES OF EDGEWOOD II

102 B QUAIL TRAIL
EDGEWOOD, NM 87015

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A 033	Continued From page 31 (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical 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	A 033		

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A 033	Continued From page 32 personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident's surrogate decision maker and outlined in the resident's individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 (11) (a) Based on record review and interviews the facility failed to ensure the safety and welfare of 1 (R #12) of 1 (R #12) residents reviewed for dementia and a history of wandering by not doing hourly checks per company policy and R #12's Individual Service Plan (ISP). This failure allowed Resident #12 to leave the facility undetected and eventually froze to death. This also has the potential for all resident's who have dementia and wander to be at risk of harm or death if caregivers fail to check on them as directed. The findings are: A. Record review of the facility Self-Report to the Licensing Authority on 12/24/15 revealed that the Administrator reported the following: 1. That during review of the facility security	A 033	A033 How all violations identified in the official statement of deficiencies will be corrected: Following this incident, the facility took the following actions: 1) Three employees involved were suspended, investigated, and their employment was terminated. 2) Chimes were installed on the exit doors to the facility to alert staff any time the doors are opened. 3) All staff were in serviced regarding the facility's policy regarding every hour checks for all residents. This policy requires staff to verify the location and condition of each resident every hour. 4) All staff were in serviced regarding the special needs of residents who have dementia or who wander, and approaches to keep these residents safe in the facility. How the facility will monitor the corrective action and ensure ongoing compliance: The facility will continue to train all new staff regarding the policy of every hour checks for all residents. Door chimes will be kept in good working condition. The facility administrator will verify that all staff are aware of the policy regarding one hour checks and that staff is complying.	01/22/16

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A 033	Continued From page 33 camera she observed that: a. At approximately 11:30 pm, R #12 returned to her room after wandering inside the facility and interacting with Caregiver (CG #10) , b. At 12:36 am, R #12 wandered out the back door of the facility and CG #10 at this time was sitting on the couch. c. From 12:36 am to 1:10 am, R #12 could be seen wandering outside the facility, and did not try to re-enter the home. d. At 1:10 am, R#12 was seen walking down the fence line and out of sight of the camera. 2. The Administrator reported: a. On 12/20/15 at 8:38 am, she was called by the House Manager who told her that R #12 was missing. b. At 8:44 am, the House Manger called again and reported that R #12 had been found outside, cold and unresponsive. c. When she arrived at the facility the Emergency Medical Team (EMT) and police department were at the facility and a few minutes later the Medical Examiner arrived and pronounced that R #12 was dead. B. On 01/14/16 at 1:44 pm, during interview with CG #9, she reported that on 12/20/16: 1. She arrived at the facility at 6:20 am. The residents were just starting to come into the dining room for breakfast, R #12 usually comes to breakfast between 7:30 am, and 7:45 am. 2. At 7:45 am, she asked CG #12 where R #12 was, CG # 12 said the R #12 was still sleeping. 3. At 7:55 am, CG #11 went to give R #12 her medications and discovered she was not there. Staff started looking for resident in both facilities but did not find her. CG #11 left again to	A 033		

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A 033	Continued From page 34 continue looking for R #12. 4. At 8:20 am, CG #11 returned to the facility saying that R #12 had been found, was unconscious, and needed help. A few minutes later the House Manager arrived. C. Record review of a New Resident Risk Agreement Contract dated 01/14/15 identifies R #12 to have Dementia and at risk for falls. D. Record review of R #12's ISP dated 01/14/15 states staff were to: 1. Conduct night checks every hour when resident was sleeping. 2. Toilet resident every 2 hours. 3. Make sure resident is safe due to wandering. E. Record review of the shift change notes for R #12, CG #10 noted that "Resident was up wondering for most of the night, no problems." CG #10 electronically signed at 4:59:16 am on 12/20/15. F. Record review of the Employee Handbook dated 01/01/15 revealed: 1. On page 10 states that bed checks "MUST BE DONE EVERY HOUR for each resident, unless resident is mentally stable and locks door." 2. On page 19 it states the the Weekend Graves 7pm-7am staff will "Check residents every hour." G. Record review of staff files for CG #s 10, 11, and 12 revealed that: 1. CG #10 signed that she had read and understood the information provided in the employee handbook on 11/12/15. 2. CG #11 signed that she had read and	A 033		

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A 033	Continued From page 35 understood the information provided in the employee handbook no date available. 3. CG #12 signed that she had read and understood the information provided in the employee handbook on 09/10/15. H. Record review of CG #10's Employee Disciplinary Form regarding the incident on 12/20/15 where R #12 left the building and froze to death revealed that CG #10 was terminated by the Administrator for not doing hourly bed checks per company policy, resulting in resident leaving the building and freezing to death. I. Record review of CG #11's Employee Disciplinary Form regarding the incident on 12/20/15 where R #12 left the building and froze to death revealed that CG #11 was terminated by the Administrator for not doing hourly checks on residents per company policy. J. Record review of CG #12's Employee Disciplinary Form regarding the incident on 12/20/15 where R #12 left the building and froze to death revealed that CG #12 was terminated by the Administrator for not doing hourly checks on residents. K. On 01/11/15 at 11:07 am, during interview with the Administrator, she confirmed that CG #s 10, 11, 12 were neglectful by in their care for R #12 resulting in her elopement and death because they did not do hourly checks per company policy and R #12's ISP.	A 033			
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to	A 034			

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A 034	Continued From page 36 this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used	A 034		

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A 034	Continued From page 37 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 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	A 034			

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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 034	Continued From page 38 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: Based on observation and interview, the facility failed to ensure that medications were stored properly and failed to maintain a system of records for narcotic medication in sufficient detail to enable an accurate reconciliation, or count. This deficient practice has the potential to affect all 11 (R #s 1-11) residents as identified on the resident census sheet provided by the Administrator on 01/11/16. These residents are at risk of not receiving their medications as order by their physicians. There is also a potential for theft and abuse by staff, resulting in the unavailability of medications. The findings: Findings related to medication storage: A. On 01/12/16 at 8:30 am, during observation of the Narcotic storage area it was noted that the	A 034		

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A 034	Continued From page 39 Narcotic medications are not stored in separate compartments for each resident. Finding related to Narcotic count and reconciliation: B. Record review of the Controlled Medication Count sheet dated 01/01/16 to 01/12/16 revealed it was not signed indicating the narcotic medication was not counted to ensure a correct accounting on: 1. 01/10/16 by first shift coming on duty. 2. 01/01/16 to 01/12/16 by third shift going off duty. 3. 01/01/16 to 01/04/16 by second shift coming on duty and first shift going off duty. 4. 01/09/16 to 01/10/16 by second shift coming on duty and first shift going off duty. 5. 01/05/16 to 01/08/16 by first shift going off duty. 6. 01/04/16 to 01/09/16 by third shift coming on duty. 7. 01/01/16 to 01/12/16 by second shift going off duty. C. On 01/12/16 at 2:30 pm, during interview with the House Manager she confirms that Narcotic medication is to be counted at each shift change and both staff counting are supposed to sign the "count sheet", and stated she was unaware the narcotic medication had to be separated by resident. 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;	A 034			

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A 034	Continued From page 40 In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for 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	A 034		

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A 034	Continued From page 41 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: 1. That oxygen cylinder tanks were stored securely, protected from accidental damage or dislocation. 2. That oxygen cylinder tanks were not stored with combustible materials or in a tightly closed space such as a closet. 3. That "Oxygen in Use" signs were posted for 4 (R #s 1, 4, 10, and 11) of 11 (R #s 1-11) residents currently residing at the facility. If an oxygen cylinder tank were to fall over damaging the valve, causing it to depressurize, or flammable items are brought into the resident's room because there is no warning sign posted, then all the residents are at an increased risk of harm or death if a fire were to occur. The findings are: Findings related to oxygen storage. A. On 01/12/16 at 7:57 am, during observation, 1 oxygen cylinder tank was observed unsecured	A 034	A034 <i>How all violations identified in the official statement of deficiencies will be corrected:</i> All controlled substances in the facility's medication cart are now separated by resident using tab dividers in the controlled medication locked drawer. The specific instances of missing signatures on the controlled drug count sheets were reviewed with the staff who worked those shifts, and the proper procedure was reviewed with them. All oxygen tanks in use in the facility have been properly secured, and only oxygen tanks in use are kept inside the building. All other oxygen tanks, whether full or empty, are now stored in an outside storage building. "Oxygen in Use" signs are now posted on or next to the door of each room where a resident is using oxygen. <i>How the facility will monitor the corrective action and ensure ongoing compliance:</i> The facility's consulting pharmacist will verify on her visits that the controlled medications are stored correctly, and that the controlled medication count sheets are complete and accurate. Any problem areas identified will be corrected per the consultant's recommendations. All oxygen tanks not in use will be stored in the outside storage building, and the administrator will monitor for this and the placement of "Oxygen in Use" signs daily in the facility.	07/05/16

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A 034	Continued From page 42 in the unventilated closet of R# 4. B. On 01/12/16 at 7:57 am, during interview with the Administrator, she confirmed that the oxygen cylinder tank was unsecured in R #4's closet. C. On 01/12/16 at 10:09 am, during observation 2 oxygen cylinder tanks were observed unsecured in R #11's room. D. On 01/12/16 at 10:09 am, during interview with Caregiver (CG #5), she confirmed that the 2 oxygen cylinder tanks were unsecured in R #11's room. E. On 1/12/16 at 10:15 am, during observation, a liquid oxygen tank used to refill smaller oxygen carriers was observed in the hall outside R #1's room unsecured. F. On 01/12/16 at 10:20 am, during observation, the 2 oxygen cylinder tanks previously observed unsecured in R #11's room were now observed unsecured in his closet. G. On 01/12/16 at 10:20 am, during interview with the House Manager, she confirmed that the 2 oxygen cylinder tanks previously observed unsecured in R #11's room were now observed unsecured in his closet. H. On 01/12/16 at 10:20 am, during observation, 17 small oxygen cylinder tanks (2 unsecured and 15 secured in card board crates) were observed in R #10's room. I. On 01/12/16 at 10:20 am, during interview with the House Manager, she confirmed that 17 small oxygen cylinder tanks (2 unsecured and 15 secured in card board crates) were observed in R	A 034		

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A 034	Continued From page 43 #10's room. Findings related to oxygen signs J. On 01/12/16 at 7:57 am, during observation no "Oxygen in Use" sign was observed to be posted on R #4's room door. K. On 01/12/16 at 10:09 am, during observation no "Oxygen in Use" sign was observed to be posted on R #11's room door. L. On 1/12/16 at 10:15 am, during observation no "Oxygen in Use" sign was observed to be posted on R #1's room door. M. On 01/12/16 at 10:20 am, during observation no "Oxygen in Use" sign was observed to be posted on R #10's room. N. On 01/14/16 at 3:25 pm, during interview with the Administrator and House Manager, they confirmed that there that there were no "Oxygen in Use" signs on the room doors for R #s 1 and 4.	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	A 035			

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A 035	Continued From page 44 administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator's designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender's orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. 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.	A 035			

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A 035	Continued From page 45 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 self-administered, administered with assistance or is administered;	A 035		

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A 035	Continued From page 46 (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 errors and the prescriber's response shall be kept in the resident's record.	A 035		

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A 035	Continued From page 47 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 NMAC Based on observation and interview the facility failed to have licensed nurses or health care professionals administer medications to 1 (R #11) of 2 (R #s 11 and 13) residents observed during medication pass. This deficient practice has the potential to affect the physical well-being of the residents through faulty assessment of the need for medications, erroneous delivery of medications, inadequate monitoring of effectiveness and side effects and failure to respond appropriately when negative consequences occur. The findings are: A. On 01/12/16 at 9:30 am, during observation, Caregiver (CG #3) entered R #11's apartment without knocking or announcing herself, handed him a pill cup and said "Here". Then she reached into the pill cup with her gloved fingers grabbed a pill and placed it in the residents mouth, handed him a cup of water and walked away. B. On 01/12/16 at 9:45 am, during interview with the House Manager, she explained the staff complete an online training for assisting residents with medication, then they have to shadow a staff	A 035	A035 How all violations identified in the official statement of deficiencies will be corrected: All staff have been educated regarding the difference between assisting with medications and medication administration. This will also be emphasized in training with all new staff as they complete the state-approved "assisting with medications" training produced by the New Mexico Health Care Association. How the facility will monitor the corrective action and ensure ongoing compliance: The administrator will make periodic observations of the staff assisting residents with self-administration of medications. Any potential errors will be corrected immediately, and any questions regarding the distinction between "assisting" and "administering" will be referred to the consulting pharmacist for clarification.	01/29/16

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A 035	Continued From page 48 member during medication pass, and then they (newly trained staff member) is shadowed during medication pass prior to being allowed to assist the residents with medication delivery on their own. The House Manager was unaware of the difference between assisting with medications and administering medications. She also stated the family is aware and gives them [Staff] permission to administer medications, when the residents are unable to do so themselves.	A 035		
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.	A 037		

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A 037	Continued From page 49 (6) All linens shall be changed as needed and at 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 (9) (10) Based on observation and interview the facility failed to ensure for the 11 (R #1-11) residents currently residing at the facility that: 1. The clean linens were stored in a well ventilated closet. 2. That laundry supplies were kept in a secured room or closet. If the clean linens are not stored in a well ventilated closet and the laundry supplies are not stored securely then residents may become ill from bacteria contaminated linens or harmed	A 037	A037 <i>How all violations identified in the official statement of deficiencies will be corrected:</i> All clean linens have been moved to a closet with more adequate ventilation and will be stored there from now on. The laundry chemicals have been moved behind a locked door in the laundry room so that residents do not have access to them. <i>How the facility will monitor the corrective action and ensure ongoing compliance:</i> The house manager will periodically check the clean linen storage for any signs that the linen closet is not well-ventilated. All staff will maintain the laundry chemicals in a locked area in the laundry room.	01/22/16	

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A 037	Continued From page 50 from ingesting or spilling the laundry supplies on their body, splashed on their face, or by falling on a slippery floor. The findings are: A. On 01/12/16 at 11:18 am, during observation, the clean linen closet was observed to not be ventilated. B. On 01/12/16 at 11:44 am, during observation of the laundry room 1 container of laundry soap and 1 container of fabric softener were observed on the shelf above the washer and dryer within reach of residents. C. On 01/12/16 at 3:35 pm, during interview with the House Manager, she confirmed that the linen closet was not ventilated and that the bottles of laundry soap and fabric softener were not stored securely and were accessible to residents.	A 037		
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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NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF EDGEWOOD II		STREET ADDRESS, CITY, STATE, ZIP CODE 102 B QUAIL TRAIL EDGEWOOD, NM 87015		
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A 043	Continued From page 51 (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: Refer to 7.8.2.43 A. (3) Based on observation and interview, the facility failed to ensure the safety and welfare of the 11 (R #1-11) residents residing at the facility by not ensuring that the self closing device on the laundry room door was functioning. This deficient practice has the potential to harm all residents should there be a fire in this hazardous area. The findings are: A. On 01/12/16 at 11:44 am, during observation, the laundry room door was observed to not latch shut despite having a self-closing	A 043	A043 <i>How all violations identified in the official statement of deficiencies will be corrected:</i> The self-closing feature of the laundry room door has been repaired so that the door now closes and latches. <i>How the facility will monitor the corrective action and ensure ongoing compliance:</i> All staff will be responsible for maintaining the laundry room door closed except when staff is using the equipment in the room. The house manager and administrator will monitor through daily rounds of the area.	01/22/16

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A 043	Continued From page 52 device in place. Inspection of the laundry room revealed it was equipped with 2 natural gas fuel fired dryers; thus qualifying the room as a hazardous area. B. On 09/16/15 at 1:45 pm, during interview with Caregiver (CG# 3) she confirmed the laundry room door does not latch shut, stating, "It should close all the way."	A 043			
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:	A 063			

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A 063	Continued From page 53 Based on observation and interview the facility failed to conduct monthly inspections of the fire extinguishers to ensure they are in proper working order in case of fire. If the fire extinguishers are not inspected monthly as required then all 11 (R #1-11) residents are at risk of harm if there is a fire and the fire extinguishers do not work properly. The findings are A: On 01/12/16 at 8:07 am, during observation, it was observed that none of the fire extinguishers in the home were being inspected monthly (per manufacture recommendation) by staff to ensure they are fully charged and in working order in case of fire. B. On 01/12/16 at 08:10 am, during interview with the Administrator, she confirmed that staff were not inspecting the fire extinguishers monthly to ensure they are fully charged and in working order in case of fire.	A 063	A063 How all violations identified in the official statement of deficiencies will be corrected: The fire extinguisher cabinets have been modified for easier access to conduct inspections. The fire extinguishers will be inspected monthly and documented on the tag attached to each extinguisher. How the facility will monitor the corrective action and ensure ongoing compliance: The facility administrator will monitor by at least monthly visual checks of the extinguishers and the documentation attached to each one.	07/05/16
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and	A 065		

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A 065	Continued From page 54 (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 Based on record review and interview, the facility failed to ensure that monthly fire drills are conducted at a minimum of once on each shift per quarter. This deficient practice may result in harm to all 11 residents (R #1-11) on the resident census list provided by the Administrator on 01/11/16 . If fire drills are not conducted on each shift once per quarter, than staff who work on shifts will not be receiving the quarterly training necessary in case of a fire on their shift, will not be prepared to perform the necessary functions to minimize the spread of fire and to assist the residents to safety. The findings are: A. Record review of the Monthly Fire Drill log dated 01/01/15 to 12/31/15 revealed fire drills were not conducted in the second quarter on the evening or night shift, in the third quarter on the evening shift and the fourth quarter on the night shift. B. On 01/14/16 at 11:45 am, during interview with the owner, she confirmed the monthly fire drills are not being conducted on each shift once per quarter.	A 065	A065 <i>How all violations identified in the official statement of deficiencies will be corrected:</i> The facility will conduct monthly fire drills on different shifts so that each shift participates in a drill each quarter. <i>How the facility will monitor the corrective action and ensure ongoing compliance:</i> The facility administrator will monitor by reviewing the fire drill records on a monthly basis.	07/05/16

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A 070	Continued From page 55	A 070			
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 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	A 070			

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A 070	Continued From page 56 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 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	A 070		

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A 070	Continued From page 57 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 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	A 070		

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A 070	Continued From page 58 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 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	A 070		

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A 070	Continued From page 59 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 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	A 070			

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A 070	Continued From page 60 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 that Caregivers (CG) met the Employee Abuse Registry (EAR) and the Caregivers Criminal History Screening (CCHSP) Requirements for 6 Caregivers (CG #s 2, 5, 7, 8, 10 and 12) of 7 (CG #s 2, 5, 7, 8, 10, 11 and 12) employee files reviewed for compliance. This deficient practice has the potential for all residents to be at risk for harm, abuse, neglect or exploitation if the facility is not completing the EAR and/or CCHSP screening on caregivers prior to their date of hire. The findings are: A. Record review of CG #2's employee file reveals a hire date of 07/02/14 and the (CCHSP) Person Summary indicates the EAR was checked 4 days later on 07/06/14. B. Record review of CG #5's employee file reveals a hire date of 09/04/14 and the (CCHSP) Person Summary indicates the EAR was checked 5 days later on 09/09/14. C. Record review of CG #7's employee file reveals a hire date of 01/04/16 and the (CCHSP) Person Summary indicates the EAR was checked 1 days later on 01/05/16. D. Record review of CG #8's employee file reveals a hire date of 01/06/16 and the (CCHSP) Person Summary indicates the EAR was checked 1 days later on 01/07/16. E. Record review of CG #10's employee file revealed a hire date of 11/11/15 and no	A 070	A070 How all violations identified in the official statement of deficiencies will be corrected: All subsequent newly employed direct care staff will be screened through the Employee Abuse Registry prior to the first day of employment. All subsequent newly employed direct care staff will also have their fingerprints submitted to the CCHSP no later than 20 days from the first day of employment. How the facility will monitor the corrective action and ensure ongoing compliance: The facility administrator will monitor for compliance on all new direct care staff hires by means of a new hire checklist, which will be in place in the personnel file for each direct care staff member.	07/05/16

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A 070	Continued From page 61 documentation available that indicates when her EAR clearance application or her fingerprints were submitted to the CCHSP. F. Record review of CG #12's employee file revealed a hire date of 09/05/15 and that her EAR clearance application was not submitted until 09/11/16, 6-days after being hired. G. On 01/12/16 at 9:00 am, during interview with the Administrator, she confirmed the EAR and CCHSP findings for CG #s 2, 5, 7, 8, 10, and 12. H. On 02/12/16 at 11:07 am, during interview with [name of director] of the CCHSP program, reported that R #10's EAR application was not received until 11/12/15, 1-day after she was hired. Her fingerprints were not submitted within 20-days resulting in her file being closed. A new EAR clearance application was received on 12/09/15 and her fingerprints for her CCHSP clearance were not received until 12/17/16, 36-days after she was hired.	A 070			