Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2184	A. BUILDING: _____ B. WING _____	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF EDGEWOOD	102 QUAIL TRAIL EDGEWOOD, NM 87015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A Full-Onsite survey was completed on 01/14/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the survey.	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.**	
A 008	7 NMAC 8.2.8 General Licensing Requirements GENERAL LICENSING REQUIREMENTS: A. Licensure is required. No person or entity shall establish, maintain or operate an assisted living facility without first obtaining a license. B. Application for licensure. An initial or renewal application shall be made on the forms prescribed by and available from the licensing authority. The issuance of an application form is not a guarantee that the completed application will be accepted, or that the department will issue a license. Information provided by the facility and used by the licensing authority for the licensing process shall be accurate and truthful. The licensing authority will not issue a new license if the applicant has had a health facility license revoked or renewal denied or has surrendered a license under threat of revocation or denial of renewal. The licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of applicable rules found to be class A or class B deficiencies as defined in Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC or has been non-compliant with plans of correction. The licensing authority will not issue a license until the applicant has supplied all of the information that is required by this rule. Any facility that fails to participate in good faith by falsifying information presented in the licensing process shall be denied licensure by the department. The following information shall be submitted to the licensing authority for approval:	A 008	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.	07/15/16

RECEIVED
JUL 11 2016
HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Owner — (X6) DATE: 7/8/16

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

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

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

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

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A 008	Continued From page 5 civil monetary penalties by the licensing authority. Failure to comply with the licensure requirements of this rule within ten (10) days of notice by the licensing authority may result in the following penalties pursuant to Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC. (1) A civil monetary penalty not to exceed five-thousand dollars ($5,000) per day. (2) A base civil monetary penalty, plus a per-day civil monetary penalty, plus the doubling of penalties as applicable, that continues until the facility is in compliance with the licensing requirements in this rule. (3) A cease and desist order to discontinue operation of a facility that is operating without a license. (4) Additional criminal penalties may apply and shall be imposed as necessary. [7.8.2.8 NMAC - Rp, 7.8.2.8 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.8 (H) Based on observation and interview the facility failed ensure that the facility license was displayed in a conspicuous place where all 8 (R #1, 2, 4-8) 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 is maintaining a current license as an Assisted Living Facility. The findings are: A. On 01/12/16 at 7:45 am, during observation the facility license was not posted in a conspicuous place where residents, visitors,	A 008		

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A 008	Continued From page 6 and staff could see it. It was observed to be posted in the nursing office in the back of the medication room. B. On 01/14/16 at 3:25 pm, during interview with the Administrator, 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	A 016		

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A 016	Continued From page 7 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010]	A 016		

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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) (7) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In	A 016		

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A 016	Continued From page 9 making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a	A 016		

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A 016	Continued From page 10 directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the department of public safety and the federal bureau of investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to	A 016		

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A 016	Continued From page 11 support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The department and department of public safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico department of health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant , 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	A 016		

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A 016	Continued From page 12 effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. 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 3 Caregivers (CG # 2, 5, and 8) employee files reviewed for compliance. This deficient practice has the potential to affect all the residents currently residing at the facility to be at risk of harm if their caregivers have a history of abuse, neglect, exploitation or is a convicted felon. The findings are: A. Record review of CG #2's employee file revealed a hire date of 12/03/13 and the CCHSP	A 016	A016 ***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.	01/05/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF EDGEWOOD	102 QUAIL TRAIL EDGEWOOD, NM 87015

(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 016	Continued From page 13 Person Summary indicates the EAR was checked 1 day later on 12/04/13. There was no documentation that CG #2's application and fingerprints (taken on 12/04/13) were submitted to the CCHSP. B. Record review of CG #5's employee file revealed a hire date of 11/02/15 and the EAR was not checked until on 11/03/15. C. Record review of CG #8's employee file revealed a hire date of 03/17/15, the EAR was not checked until on 03/30/15, and the CCHSP clearance was not received until 05/12/15. D. On 01/12/16 at 9:00 am, during interview with the Administrator, she confirmed the above EAR and CCHSP findings for CG's #2, 5, and 8.	A 016		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge;	A 020		

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A 020	Continued From page 14 (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 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	A 020		

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A 020	Continued From page 15 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 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.	A 020		

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A 020	Continued From page 16 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 resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that	A 020		

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A 020	Continued From page 17 are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 C, D Based on record review and interview the facility failed to ensure for 2 (R #s 1 and 2) of 2 (R #s 1 and 2) residents reviewed for receiving hospice services from an outside provider had completed the following: 1. Held Exemption/Retention team meetings prior to admitting or retaining a resident who has elected to receive hospice services. 2. Updated resident's Individual Service Plans (ISP's) to reflect the coordination of care between the facility and the hospice 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. Record review of R #1's Resident file revealed that her ISP was not updated to reflect the coordination of care provided between the facility and hospice after the team meeting was	A 020	A020 ***How all violations identified in the official statement of deficiencies will be corrected:*** 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. ***How the facility will monitor the corrective action and ensure ongoing compliance:*** 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 18 held on 04/03/14. B. On 01/11/16 at 2:45 pm, during interview with the Administrator, she confirmed that R #1's ISP was not updated to reflect the coordination of care between the facility and the hospice provider after the team meeting was held on 04/03/2014. C. Record review of R #2's Resident file revealed that there was no Exception/Retention team meeting held prior to being admitted to hospice. D. Record review of R #2's ISP revealed no documentation indicating coordination of care between the facility and the hospice provider. E. On 01/11/16 at 3:26 pm, during interview with the Administrator, she confirmed that there was not an Exception/Retention meeting held when R #2 was admitted to hospice and that her ISP does not reflect any coordination of care between the facility and the hospice provider.	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	A 025		

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A 025	Continued From page 19 in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (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	A 025		

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A 025	Continued From page 20 minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A, B 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 2 (R #s1 and 2) of 4 (R #s 1, 2, 4 and 7) residents whose evaluations were reviewed for compliance. This deficient practice could result in a delay in care, services, and assistance the residents need due to a change in condition, resulting in possible complications and the need for medical intervention. The findings are: A. Record review of R #1's Resident Evaluations dated 11/08/13 and 01/05/16, revealed over 2 years between evaluations. B. On 01/11/16 at 2:45 pm, during interview with the Administrator she confirmed that R #1's evaluations had not been reviewed and updated a minimum of every 6 months or when there is a change of condition. C. Record review of R #2's Resident Evaluations revealed an evaluation was completed on 10/16/13, resident was not admitted to the facility until 01/02/14, 2-1/2 months after the initial evaluation. R #2's next	A 025	A025 ***How all violations identified in the official statement of deficiencies will be corrected:*** 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. ***How the facility will monitor the corrective action and ensure ongoing compliance:*** 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.	01/05/16

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A 025	Continued From page 21 evaluation was dated 01/05/16, over 2 years between evaluations. D. On 01/11/16 at 3:16 pm, during interview with the Administrator she confirmed that R #2's initial evaluation was not completed within 15 days prior to admission, that her evaluations had not been reviewed and updated a minimum of every 6 months, or when there is a change of condition.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided;	A 026		

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A 026	Continued From page 22 (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: 7.8.2.26 A , B (7) Based on record review and interview the facility failed to ensure that the Individual Service Plans (ISP) for 4 (R #s 1, 2, 4, and 7) of 4 (R #s 1, 2, 4, and 7) residents whose ISP's were reviewed for compliance by: 1. Were completed within 10 days of admission. 2. Have services documented that are 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. This deficient practice has the potential for the residents to not receive the appropriate care and assistance they need upon admission and changes in their health status occurs because the ISP's are not updated, complete, and accurately	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 and will be completed within 10 days of admission. ***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 23 reflect the needs of the resident. If the direct care staff do not understand what the expected goal/outcome of the care they provide is then the residents may not achieve or maintain their highest level of mental or physical function. The findings are: A. Record review of R #1's resident file revealed that her latest ISP was dated 11/10/13. B. Record review of R #1's resident file revealed that her ISP was not updated to reflect the coordination of care between the facility and hospice provider after the team meeting was held on 04/03/14. C. Record review of the facility Staff Meeting Notes revealed care meetings for R #1 were held on 03/26/14 and 04/03/14 when she was placed on Hospice, however, there were no updates made to her ISP. D. Record review of R #1's ISP revealed that it did not include any expected goals and outcomes. E. On 01/11/16 at 2:45 pm, during interview with the Administrator she confirmed that R #1's ISP had not been updated and reviewed a minimum of every 6 months or when R #1 was admitted to Hospice. The Administrator stated that she thought they only had to be reviewed annually. She also confirmed that R #1's ISP did not contain any expected goals and outcomes. F. Record review of R #2's resident file revealed ISP's dated 01/09/14 and 09/02/15, 8 months between reviews. G. Record review of R #2's ISP's revealed	A 026		

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A 026	Continued From page 24 no documentation of coordination of care with the hospice provider or any expected goals and outcomes. H. On 01/11/16 at 3:16 pm, during interview with the Administrator, she confirmed that R #2's ISP was not reviewed and updated every 6 months, or when she was admitted to hospice and did not include any expected goals and outcomes. I. Record review of R #4's resident file revealed an admission date of 09/01/15 and an ISP dated 09/23/15, 22-days after admission. J. Record review of R #4's ISP dated 09/23/15 revealed that it did not include any expected goals and out comes. K. On 01/11/16 at 3:47 pm, during interview with the Administrator, she confirmed that R #4's ISP was not completed within 10 days of admission and did not include any expected goals and outcomes. L. Record review of R #7's resident file revealed: 1. An admission date of 10/07/15 and an ISP dated 11/03/15. 2. The ISP did not include any expected goals and outcomes. M. On 01/11/16 at 4:09 pm, during interview with the Administrator, she confirmed that R #7's ISP was not completed within 10-days of admission and did not include any expected goals and outcomes.	A 026		
A 034	7 NMAC 8.2.34 Custodial Drug Permits	A 034		

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A 034	Continued From page 25 CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular	A 034		

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	2184	A. BUILDING: _____ B. WING _____	01/14/2016

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BEE HIVE HOMES OF EDGEWOOD	102 QUAIL TRAIL EDGEWOOD, NM 87015

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A 034	Continued From page 26 pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be	A 034		

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A 034	Continued From page 27 reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper storage of medications and failed to maintain a system of records for narcotic medication in sufficient detail to enable an accurate reconciliation or count. If the facility does not ensure that medications are stored properly and narcotic medications being counted regularly then all 11 residents (R #s 1-11) identified on the resident census sheet provided by the Administrator on 01/11/16 are at risk of not receiving their medications as the physician has ordered. There is also the potential for theft and abuse by staff, resulting in the residents not having the medication available when they need it. The findings are:	A 034		

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A 034	Continued From page 28 Findings related to medication storage: A. On 01/12/16 at 1:30 pm, during observation of the narcotic storage area it was noted that the 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 through 01/11/16 was not signed to indicate the narcotic medication was counted and correct on: 1. 01/02/16 by day shift coming on duty and night shift going off duty. 2. 01/05/16 to 01/10/16 by night shift going off duty. 3. 01/01/16 to 01/10/16 by evening shift coming on duty and day shift going of duty. 4. 01/01/16 to 01/11/16 by day shift going off duty. 5. 01/09/16 to 01/12/16 by night shift coming on duty and evening shift going off duty. 6. 01/04/16 to 01/09/16 by night shift coming on duty. 7. 01/01/16 to 01/12/16 by evening shift going off duty. C. On 01/12/16 at 2:30 pm, during interview with the House Manager she confirmed that Narcotic medication is to be counted at each shift change and both staff counting are supposed to sign the "count sheet", she also stated she was unaware the narcotic medication had to be separated by resident.	A 034	A034 ***How all violations identified in the official statement of deficiencies will be corrected:*** 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. ***How the facility will monitor the corrective action and ensure ongoing compliance:*** 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.	01/05/16
A 037	7 NMAC 8.2.37 Laundry Services	A 037		

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A 037	Continued From page 29 LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at 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	A 037		

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A 037	Continued From page 30 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: Based on observation and interview the facility failed to ensure clean linens were stored in a well ventilated closet and laundry supplies were kept in a secured room or closet for 8 residents (R #s 1, 2, 4-8) of 8 (R #s 1, 2, 4-8) residents currently residing at the facility. 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 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 11:20 am, during observation the clean linen closet was observed to not be ventilated. B. On 01/12/16 at 11:20 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. The laundry room is not locked and is accessible to residents (some with dementia). C. On 01/12/16 at 3:35 pm, during interview with the House Manager, she confirmed that the linen	A 037	A037 ***How all violations identified in the official statement of deficiencies will be corrected:*** 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. ***How the facility will monitor the corrective action and ensure ongoing compliance:*** 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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	2184	A. BUILDING: _____ B. WING _____	01/14/2016

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A 037	Continued From page 31 closet was not ventilated and that the bottles of laundry soap and fabric softener were not stored securely and accessible to residents (some with dementia).	A 037	A038 ***How all violations identified in the official statement of deficiencies will be corrected:*** All soiled cleaning rags and cleaning chemicals have been removed from the food storage area. Cleaning chemicals are now stored in a locked cabinet separate from food storage. ***How the facility will monitor the corrective action and ensure ongoing compliance:*** Cleaning chemicals and supplies will not be stored in the same area as food storage. The house manager and/or administrator will monitor by daily rounds through the kitchen and pantry areas.	01/22/16
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that cleaning rags and other flammable substances were stored away from	A 038		

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A 038	Continued From page 32 food. This deficient practice has the potential to harm any of the 8 residents (R #1-8) currently residing in the home if they were to ingest food contaminated by the chemicals, drink or spill cleaning supplies on their face or body. The findings are: A. On 01/12/16 at 3:26 pm, during observation the following chemicals and cleaning rags were observed to be stored in the pantry: 1. 1-12 oz stove cleaner 2. 1-26 oz liquid Bar top cleaner 3. 1-24 oz cleaner with bleach 4. 2-18 oz hard water remover 5. 1 spray bottle containing bleach and water 6. 1 open bucket of cleaning rags (combustible) B. On 01/12/16 at 3:35 pm, during interview with the House Manager, she confirmed that the cleaning supplies and rags (combustible) were in the pantry, that they should not be stored with the food, and need to be stored in a locked/secure place where residents do not have access.	A 038		
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	A 063		

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A 063	Continued From page 33 extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Based on observation and interview the facility failed to 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 8 (R #1-8) 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 8:04 am, during observation, it was observed that none of the fire extinguishers in the home were being inspected monthly by staff to ensure they are fully charged and in working order in case of fire. B. On 01/12/16 at 8:10 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	A 065		

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A 065	Continued From page 34 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 (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 A, B(1) 7.8.2.65 Based on record review and intrerview, 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 9 residents (R #1-9) on the resident census list provided by the owner 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 065	A065 ***How all violations identified in the official statement of deficiencies will be corrected:*** The facility will conduct monthly fire drills on different shifts so that each shift participates in a drill each quarter. ***How the facility will monitor the corrective action and ensure ongoing compliance:*** The facility administrator will monitor by reviewing the fire drill records on a monthly basis.	01/05/16

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A 065	Continued From page 35 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 first quarter on the night shift, in the third quarter on the night shift and the fourth quarter on the evening 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		
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	A 070		

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A 070	Continued From page 36 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 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,	A 070		

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A 070	Continued From page 37 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 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]	A 070		

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	2184	A. BUILDING: _____ B. WING _____	01/14/2016

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A 070	Continued From page 38 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 rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . .	A 070		

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A 070	Continued From page 39 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 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.	A 070		

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A 070	Continued From page 40 (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 3 Caregivers (CG # 2, 5, and 8) employee files reviewed for compliance. This deficient practice has the potential to affect all the residents currently residing at the facility to be at risk harm if their caregivers have a history of abuse, neglect, exploitation or is a convicted felon. The findings are: A. Record review of CG #2's employee file revealed a hire date of 12/03/13 and the CCHSP Person Summary indicates the EAR was checked 1 day later on 12/04/13. There was no documentation that CG #2's application and fingerprints (taken on 12/04/13) were submitted to the CCHSP. B. Record review of CG #5's employee file	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.	01/05/16

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A 070	Continued From page 41 revealed a hire date of 11/02/15 and the EAR was not checked until on 11/03/15. C. Record review of CG #8's employee file revealed a hire date of 03/17/15, the EAR was not checked until on 03/30/15, and the CCHSP clearance was not received until 05/12/15. D. On 01/12/16 at 9:00 am, during interview with the Administrator, she confirmed the above EAR and CCHSP findings for CG's #2, 5, and 8.	A 070		