STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2144	A. BUILDING _____ B. WING _____	C 06/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF SAN PEDRO - BUILDING	6401 CORONA ALBUQUERQUE, NM 87113

(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 01	OPENING REMARKS Two (2) complaint investigations were completed on 6/21/2010 for NMAC 7.8.2-New Mexico Regulations Governing Adult Residential Care Facilities. 1. Intake #'s NM00026850 and NM00027615 regarding Care and Services - UNSUBSTANTIATED Food/Nutrition - UNSUBSTANTIATED 2. Intake # NM00027451 regarding Medications- SUBSTANTIATED	A 01		
A36	7 NMAC 8.2.36 Medications 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws. A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. C. 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 by the physician and entry into the	A36		

Scanned 07-08-10

Correction on pg 3.

RECEIVED JUL 2010 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7-5-10

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A36	Continued From page 1	A36		

resident's record.

D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects.

E. Medications prescribed for one resident shall not be used for another resident.

F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include:

(1) Name of resident.
(2) Date started.
(3) Drug product name.
(4) Dosage and form.
(5) Strength of drug.
(6) Route of administration (e.g. "by mouth").
(7) How often medication is to be taken.
(8) Time taken and staff initials.
(9) Dates when the medication is discontinued or changed.
(10) The name and initials of all staff administering medications.

G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting.

H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions:

(1) The resident is capable of determining when the medication is needed.
(2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include:

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A36	Continued From page 2 (a) Symptoms that might indicate the use of the medication. (b) Exact dosage to be used. (c) The exact amount of medication to be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist. (e) Possible interactions or side-effects that might occur. (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.36 (C) - Medications Based on record review and interviews, the facility failed to ensure that medications administered were done so with current physician's orders for (1) facility resident. The findings are: A. On 6/7/2010 during review of intake #27451 it was alleged that Resident #1 who was a resident of the facility was hospitalized due to shoulder swelling. The complaint alleged that during this hospitalization in 2009 he was taken off of previously prescribed Coumadin (Warfarin for blood thinning) during hospitalization. The complaint alleges that the facility continued to administer Coumadin to Resident #1 after he returned to the facility with physician's hospital discharge orders which included instructions to	A36	In response to the complaint survey on 6-21-2010, the following corrective actions have been put in place. The manager from the incident on 1-30-2010 is no longer with the Beehive Village. A new manager is in now in place. All Doctor's orders are now being addressed as they come into the facility. We at the Bee Hive recognize that this incident can impact 100% of our residents. The new manager is pro-active in monitoring all current and incoming Doctor's orders, be it medication or orders pertaining to resident's well being. With the above corrections in place all Doctor's orders have been addressed upon receipt of said order as of May 1st 2010.	

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A36	Continued From page 3	A36		

discontinue the Coumadin. It is alleged that this ongoing medication error was not discovered for some time after the resident returned to the facility.
B. Interview with Interviewee #1 on 6/7/2010 at 9:34 AM he reports that this situation involves a resident of the facility. He reports that the facility is at fault for medication error involving Resident #1. He reports that last year Resident #1 was sent to the hospital for a bleed in the shoulder which he states as being result of having been lifted incorrectly by the facility. Subsequently, upon the resident ' s return to the facility, Resident #1 was given all prescribed medications that he had been on prior to hospitalization. One of those medications was the blood thinner Coumadin (Warfarin). However, Interviewee #1 stated, during the hospitalization, the Resident #1's Coumadin was discontinued in the hospitalization process and he was no longer supposed to be given that medication upon discharge from the hospital.
C. Interview with the House Manager at 3:40 PM on 6/16/2010 revealed Resident #1 is not currently on Coumadin. She reports that the physician ordered the medication to be discontinued on 1/30/2010 and reports that facility documentation by the previous manager and facility pharmacist which indicates that the medication was not discontinued until 2/6/2010 as ordered.
D. Review of facility records on 6/21/2010 revealed a physician order to discontinue the Coumadin for Resident #1 effective 1/30/2010 as well as documentation in facility (Bluestep Medication Administration Record) software to indicate that the medication was not stopped until 2/6/2010.