STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING _____ B. WING _____	C 10/20/2006

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BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE RIO RANCHO, NM 87124

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A 01	OPENING REMARKS A complaint investigation was conducted from 10/10/06-10/20/06. Complaint #NM 24369 was SUBSTANTIATED with Deficiencies cited.	A 01		
A13	7 NMAC 8.2.13 GROUNDS FOR REVOCATION OR SUSPENSION OF LICEN 7.8.2.13 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES: A. When the Licensing Authority determines that an application for renewal of a license is to be denied, or that a license is to be revoked, the Licensing Authority shall provide written notification to the adult residential care facility, the residents of the adult residential care facility and the surrogate decision maker for the resident. B. A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons: 1. Failure to comply with any provision of these regulations. 2. Failure to allow a survey by authorized representatives of the Licensing Authority. 3. Hiring or retaining any employee who has been convicted of a felony or misdemeanor related to abuse, neglect or exploitation, trafficking in controlled substances, criminal sexual penetration or related sexual offenses. 4. Misrepresentation or falsification of any information on application forms or other documents provided to the Licensing Authority.	A13	Scanned 1-4-07	

Jacqueline Dawson Administrator

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A13	Continued From page 1 5. Discovery of repeat violations of these regulations. 6. Failure to provide the required care and services as outlined by these regulations for the residents receiving care from the facility. 7. Exceeding licensed capacity. 8. Failure to provide an acceptable plan of correction. 9. Abuse, neglect or exploitation of any patient/client/resident by facility operator, staff or relatives of operator/staff. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 6-15-98; 7.8.2.13 NMAC - Rn, 7 NMAC 8.2.13, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7 NMAC 8.2.13(B)(1)(6)(9). Cross Reference to 7 NMAC 1.13.8 and 7 NMAC 1.13.10 A-F Incident Management System Reporting Requirements For Licensed Health Care Facilities Based on observation record review and interview, the facility neglected to train and supervise caregiver staff resulting in an accident with critical injuries and subsequent death of one of eleven residents (#1). Additionally, the facility failed to implement an Incident Management System designed to protect residents from abuse, neglect and exploitation. (Cross reference tag 17, 33, 34). A. On 10/10/06 at 11:00 a.m., during an interview, the Administrator stated that an incident occurred on Monday 10/9/06 in which Caregiver #4 was transporting Resident #1 to her scheduled physician's appointment. According to the resident's medical record reviewed on 10/10/06,the resident was an 85-year-old female	A13	A) Caregiver #4 had taken Resident #1 to the doctor at West Mesa Provillion behind the hospital. Caregiver #4 had demo-strated the procedure of Loading and unloading the Resident prior to Appt. that day. In the furture we as Bee Hive Homes of Rio Rancho # II the Administrater will be the only one transporting the Resident. i) not all employee's are trained to do trans-portation of Residents. In the past it has only been myself that has ~~been~~ done transporting. This was the only time we had used another person beside myself. The training file on Resident #4 is in her file, that consist of transportation certifcate, to get the certifaccation	

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A13	Continued From page 2 who was alert, oriented, able to make her needs known, and who primarily used a wheelchair for ambulation. On the return trip to the facility from the physician's appointment, Caregiver #4 had a motor vehicle accident. Because Resident #1 was not restrained in her wheelchair, nor was the wheelchair locked into the van, she was critically injured when the van struck a curb and road sign. An investigation revealed that Caregiver #4 made no attempt to call 911 or to drive to a local hospital to seek medical assistance. Instead, the caregiver returned to the facility, four miles from the accident site, and asked for help there. Resident #1 died as a result of the injuries sustained in the accident. 1. Transportation training file(s) for employees were requested but not provided on 10/12/06 at 12:30 pm. The administrator stated that they used a training workbook but they just "talked about things." She also said that "we never did any dry runs with the van; all it was, was just going through a workbook." In an interview on 10/10/06 at 4:15 pm the Administrator stated that "we haven't done any training here that much" and then later, on 10/11/06 at 12:30 pm, the owner said "What sorts of training would you need to tranport someone? It's not rocket science to put someone in the car." Transportation policies and procedures were requested. A review of the Policy Manual dated 5/25/01 just stated that "the facility may arrange transportation as requested. . ." No other policies were available. During an interview on 10/10/06 at 11:00 a.m., the administrator outlined her knowledge of the events leading up to the incident. She also answered questions regarding the type and scope of transportation and wheelchair restraint training she provided. Specifics of that incident	A13	She demostrated loading and unloading Residents Locking and unlocking Resident. which employee #4 demostrated with out difficulties. FOR extra security I Reminded her to put hand over Residents / head to make sure she didnt hit her head on the van frame. and the seatbelt is to be tightened just like your own baby would be. In the furture only the administrator will be doing transporting if there is Any to be done.	

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A13	Continued From page 3 are as follows: The administrator said that Caregiver #4 volunteered to drive Resident #1 to her doctor's appointment and she agreed to let her. On the morning of 10/9/06, she gave Caregiver #4 step-by-step instructions on how to properly secure the resident in the facility transportation van. She said that she also demonstrated it. The administrator did indicate that caregiver #4 needed reminders during the training proceess. The administrator reported that when originally loading the resident into the van, she had to keep reminding the caregiver to put her hand on the resident's head so she would not hit her head on the top of the van. Upon arrival to the physician's office, the administrator stated that again, "I had to remind her about not hitting her [Resident #1's] head on the van, and I also had to remind her about making sure the safety belt was tight." She confirmed, "This was the caregiver's first transfer and also her very first time driving the facility transportation van." The administrator said that she also drove to the physicians appointment, but she drove her own vehicle, driving ahead of the van. She indicated that she left the resident with the caregiver and returned to the facility. The administrator confirmed that she did not ever ride in the van with the caregiver driving to observe her driving. 2. The administrator then stated she got a call from the Manager telling me, "I need you to come over here, [name of resident] is bleeding." The administrator stated that upon arrival at the facility, "Resident #1 was lying behind the drivers seat. Her feet were by the drivers seat. Her head was where the wheelchair was supposed to be. She was lying at an angle. I saw her in the van, and she had blood on her head." 3. On 10/10/06 at 11:30 a.m. during an	A13		

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A13	Continued From page 4 interview, the Owner of the facility stated that the EMT said the resident had no pulse. The owner further stated that when he called the family, he stated, "There was an accident, I believe she has died and have reason to believe we were at fault." On 10/10/06 at 11:45 a.m., during an interview, the Administrator stated, "There was no way the resident could have gotten out of her wheelchair or even moved herself side to side." 4. On 10/10/06 at 12:15 p.m., during an interview with Cook/Employee #2 (who was the first person from the facility to respond), he stated that, "As she [Caregiver #4] came here, her hands were covered in blood. I went outside to the van and it appeared that [name of Resident #1] had hit her head. Her head was facing the seat, she was lying on her back and her head was lying to the side. I shook her a little bit from her legs and said are you okay. She was gurgling. I rolled her on her back to assess her. It appeared that she might have had a petechial hemorrhage to her left eye and a massive laceration to the bridge of her nose." 5. On 10/11/06 at 7:30 a.m., during an interview with the Office of the Medical Investigator, it was stated by the investigator that an autopsy was conducted on 5/10/06 and the cause of death was "Blunt force injury of neck" and "Partial Occipital Separation." 6. On 10/11/06 at 8:32 a.m., during an interview, a Deputy Field Investigator stated, "I was notified at 11:50 a.m. by dispatch. When I got there the body was in the van. But, before that, I stopped at McMahon and Golf Course (where the incident occurred) and got an explanation from the officer what happened. I timed the mileage, which was 4.6 miles." The Field Investigator further stated, "When I arrived on the scene I looked at her. I was told by EMT that they had already declared her dead.	A13		

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A13	Continued From page 5 She was in the back of the van, around the area where the w/c would be. Her legs were stretched toward the front passenger door and seat. If I'm correct, this would not have happened if she was securely fastened in her wheelchair and if the wheelchair was securely fastened in the van." The Field Investigator also stated, "I checked the seat belt. It had no cuts, rips, or fraying. It was in good shape, and I do not think it was a malfunction. It looked in good shape to me. I know her skull separated from her atlas meaning the first vertebrae from her spinal column separated, hense a broken neck. There was a dislocated right shoulder, based on what it looked like, some lacerations to face, small cuts made by impact these were Deep Rips. The lower part of her nose and forehead had blood on it." The investigator indicated that the console that sat between the two front seats "was all bloody and there was blood on the floor. When I saw her, she was on her back, the head was where the wheelchair would have been and her feet were diagonally towards the back. 7. On 10/11/06 at 12:30 p.m., during an interview, the Owner of the facility stated, "She [Caregiver #4] did not lock the apparatus and did not lock the wheelchair. She went down the road the wrong way, then over the median." 8. On 10/11/06 at 1:45 p.m., Employee #2 was interviewed because he was the first facility staff on the scene to give assistance to Resident #1. He stated, "Her head was behind the driver's seat towards the side a little bit. The wheelchair was next to her, and I saw one of the rear back wheels that was not attached, and kinked to the side. That's how I knew it [the wheelchair] wasn't securely attached to the van." B. On 10/19/06 at 12:33 p.m., during an interview, a family member of Resident #1	A13		

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A13	Continued From page 6 alleged that facility staff also neglected the resident on a different occasion. She stated that the resident moved in on 8/12/06, and "The next morning the manager called to report that the resident was found lying on the floor in her room and had probably been there all night." The family member further stated, "They were supposed to be checking on her every 30 minutes; that was in the contract." The family member reported that the resident told her she had spent the whole night on the floor; no-one helped her, and she was cold. The family member also said that when the administrator was asked about this, the administrator said that Staff #6 checked on her every 30 minutes and reported on the that at 6:30 a.m. when he left the resident was in bed. Review on 10/19/06 of the resident's entire chart revealed no documentation of this incident that allegedly occurred on 8/13/06. Additionally, no facility incident report was located. Based on review of the intake database on 10/19/06, there was no documentation that a report was made to the state agency regarding the alleged neglect. C. On 10/12/06 at 11:25 a.m., review of the State Central Intake Database for Reporting Incidents verified that no one from the facility had reported the incident to the Department of Health. On 10/12/06 at 12:30 p.m., the facility Administrator was interviewed regarding the facility's compliance with Incident Management guidelines. The Administrator stated, "Our policy is what I did. I called the 1-800 number and talked to SCI. (State Central Intake)." She said, "We keep incident reports in the book and the report goes with the Incident report. We just go by what happened. We went from what we learned from House 1, and are learning from	A13	The incident that was Surpose to have happen on 8/12/06. When I did an interal investation I had found that all documentation supported that she was in the bed Then out the night The documentation was laid out for the unspecter to Review on date 10/19/06. The manager was going on what the resident was saying. When the manager called me and I was made aware of the incident I came in to do the investigation. After I was done with the investigation I had found no such incident happened. I talked to the resident and she Stated she was cold and the lady in the Kitchen (manager) put her there. On the further I have included the Staff to do rounds.	

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A13	Continued From page 7 those mistakes, and how to prevent them from happening here. So, if something were to happen, we make sure it doesn't happen again." Review of policies and procedures and training documents, and observations throughout the survey of lack of required posters, revealed noncompliance with Incident Management Guidelines. When asked about employee training, the Administrator stated, "They (the employees) get a whole packet to take home, the managers go through it with them and they take a quiz. We tell them, take the packet home, if you have any questions, you need to ask me. The administrator provided a copy of the training curriculum of "Abuse, Neglect, and Exploitation" the facility was using and stated, "This is what we got from you guys at APS." The Administrator further stated, "All we do as far as checking things, is get a copy of their license and social security card and we go through the training packet. 2. Review of the identified "training curriculum" that was given to new employees revealed that the training curriculum the Administrator referenced was from New Mexico Children Youth and Families Department, Adult Protective Services. The training curriculum was focused on training individuals in the community to recognize abuse and neglect. One section stated that the process for reporting was as follows: "1. Process for Making Referrals to CYFD Statewide Central Intake 2. Provide all relevant information to the SCI Social Worker..." The correct reporting mechanisms were not listed. The Administrator verified, "This is what we use as our training curriculum, emergency action procedures, and how to respond to Abuse and Neglect."	A13	With the shift that they are relieving that way if something happened it could be corrected at once with no lead say. 1-C The poster where given to me for the II Home in July by DHI at a meeting with Anita Westbrook. The poster where put up at the beginning of us opening in Aug. We had our opening inspection on 8/29/06. At that time during the Survey done on 8/29/06 the Poster where up, and they Violation wasn't written by Consuela maintained due to that Reason. While having new resident in the Posters was taken and fill down. They where Placed away and	

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A13	Continued From page 8 E. On 10/12/06 at 2:00 p.m., during an interview, the Administrator was asked, "Do you use the Federal definitions of Abuse, and Neglect?" The Administrator stated, "This is what I go by (referring to the CYFD/APS training manual). It says step-by-step what abuse is, and what neglect are." The administrator further stated, "It describes employee stress management for the employees to prevent them from getting to the point to where they would commit abuse or neglect." Review of the manual did not reveal definitions required by the Incident Management system. When the Administrator was asked about the incident report regarding the death of Resident #1 that occurred on 10/9/06, the administrator stated, "I still don't know what to fill out, I don't know what happened. I haven't got a clear understanding of what happened so how would I go about filling this report out." F. Review on 10/12/06 of the facilities Incident and Complaint Policy dated 5/25/01 revealed the following statements: 1. Resident Grievance Procedure: Each incident will be documented and investigated... All staff members are encouraged to report any knowledge they may have of wrongful treatment... 2. [Name of the facility] will insure that all suspected cases or known incidents of residents abuse, neglect, exploitation, and mistreatment are reported. [The facility] will also report any incident...that has or could threaten the health, safety, or welfare of the residents to the Licensing Authority... by the next business day. In no instance will [the facility] delay a report... to the Licensing Authority... 3. [Name of the facility] will be responsible for documenting all incidents within five days of the incident...	A13	when we replaced them with the posters at DHI office they had the wrong ones with the wrong number. on 12/12/06 the ombudsman gave me the posters with the right number. In the future Bee Hive Homes will check with each agency to make sure all posters are correct and up at all times. 2) Regarding the reporting of the incident on 10/9/06. I phoned it in to APS and spoke with a Mr. Edwards I told him about the situation here at Bee Hive informed him how do I go about putting this on paper to fax it because of what type of incident and I don't know what happened. He informed me to talk to one of the inspectors if they come when the inspector came on 10/10/06 I told her I knew someone would be coming and can you help me with the report. Since I don't	

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A13	Continued From page 9 G. During the entire time of the complaint investigation conducted from 10/10/06-10/20/06 numerous observations revealed no postings of the Incident Management Posters regarding information on reporting Abuse, Neglect, and Exploitation. 1. On 10/12/06 at 12: 45 p.m., during an interview, the administrator stated "those should be next to the Ombudsman posters." 2. On 10/12/06 at 4:59 p.m., a fax was received from the administrator that stated, "Poster are not put up. That is in, #1 Home. They fell down and was throwed [sic] away in [name of the facility]." 3. On 10/13/06 at 7:45 a.m., during an interview, the Assistant Manager stated, 'No, I've never seen any posters posted here. I don't even know what they would look like. We haven't had any here that I'm aware of." 4. On 10/13/06 at 9:00 a.m., during an interview, the Assistant Manager was asked "how do you as staff know what to report or who to report suspected abuse, neglect to?" The Assistant Manager stated, "I don't know where the Incident Reports are kept, if they fall or need to be sent to the hospital we call [the manager or administrator]." The Assistant Manager was also asked, "what do you do if both the manager and administrator are unavailable?" The Assistant Manager reported, "Honestly, I wouldn't know what to do, I don't know the 1-800 #'s or even where that is. I guess I would just find a Incident form and fill that out the best I could." 5. On 10/13/06 at 9:15 a.m., during an interview, the Manager stated, "I haven't seen any posters in here, there isn't any that I know of." The Manager further stated, "Since I've been here at this house, we haven't had no training on abuse, neglect, or exploitation that I know of. I	A13	have any information yet on what happened. She informed me no I can't but put what you know which is nothing at the time of inspection after I spoke with Anita West Brook and inspector in her office. Anita just told me to write being investigated by the Authorities So on 12/11/06 I faxed the report with what I had found out at that point. In the future I will fax all reports within guide line times even if they are incomplete. 6) When we opened the house I took the manager to the side and went over each notebook in the Cabinet which is. Policy and procedure, incident and Complaint, OSHA, emergency manual, medication and first aid, Inservice manual, Hippa Regs, employee guidelines and Pharmacare Pharmacy. She was instructed where all forms are in the books and what she had to tell her employees. The assistant manager has written a reply to the Section about her. I don't know where any of that conversation is coming from. In the future when	

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A13	Continued From page 10 would have to look through a book to find out who to call for a phone number. I don't really know where to look."	A13	instructing the staff at any degree they will be signing a notation stating what was taught to them.	
A17	7 NMAC 8.2.17 PERSONNEL 7.8.2.17 PERSONNEL: The adult residential care facility must have and implement written personnel policies. The personnel policies must address the following: A. Qualifications for all professional and non-professional disciplines. B. Staff conduct which must foster resident safety and well-being and must not be detrimental to resident care. C. Staff training, appropriate to staff responsibilities, including, at a minimum, an orientation and an on-going, but at least annual, program which includes: Fire Safety, First Aid, Safe Food Handling practices, Confidentiality of Records and Resident information, Infection Control, Resident Rights, Reporting Requirements for Abuse, Neglect, and Exploitation, Transportation Safety for Assisting residents and operating vehicles to transport residents and Providing Quality Resident Care based on current resident needs. D. Employee personnel records, including an application for employment, TB tests and certificates, training records, and personnel actions. [4-7-97; 7.8.2.17 NMAC - Rn & A, 7 NMAC 8.2.17, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7 NMAC 8.2.17 Based on record review and interview, the facility	A17 A-17 A.1 A.2	A.1 Employee #1 I am not sure who that employee is I can't get a guideline on what number belongs to who. But all employee that are here now has training documentation. A.2 Employee #3 does not have transportation we don't train everyone that is employed on	

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	2106	A. BUILDING _____ B. WING _____	C 10/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE RIO RANCHO, NM 87124

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A17	Continued From page 11 failed to ensure 7 of 9 employees (#1, 3, 4, 5, 6, 7 and 8) had an orientation and on-going/annual training program that included Fire Safety, First Aid, Infection Control, Resident Rights, Reporting Requirements for Abuse, Neglect, and Exploitation, and Transportation Safety for Assisting residents and operating vehicles. The findings are: A. On 10/11/06 at 12:15 p.m., during review of the employee personnel files for employees #1, 3, 5 and 6 the following was noted: 1. Employee #1 was hired at this facility on 8/8/06. No documentation of an orientation, current trainings, or in-service trainings for Fire Safety, First Aid, Infection Control, Resident Rights, Reporting Requirements for Abuse, Neglect and Exploitation and transportation Safety for Assisting residents was located in the employee file. 2. Personnel file for Employee #3 (Assistant Manager) revealed no documentation of transportation training. In interview at that same time the assistant manager confirmed she had not received any training on transporting residents. Employee #3 was hired 9/12/05 at a different facility. She stated that she transferred to this facility "about two months ago." The personnel file reflected that she had received abuse, neglect training at the first facility, but none while employed at this one. 3. Personnel file for Employee #5 had no documentation of an orientation or training on first aide. 4. Personnel file for Employee #6 who was hired on 8/9/04 had no documentation of any trainings for 2006. B. On 10/13/06 at 9:15 a.m., during an interview, the Manager stated, "I came here on August 8.	A17	transporation. Abuse neglect, explanation was done on 10/23/06. She did attend. A-3) I do not know who employee #5 is. I have everyone training record in there file. CPR Class was done on 8/26/06 A-4 Employee #6 inservices where May 01, 2006 Abuse, neglect, explotation Review, 8/24/06 CPR and first aid, 2/06 blood born pathogen, Policy and procedure Review. In the future we will have a visible list of all inservices done here at the home for the employees Plus a copy up there chart. B) The abuse, neglect explanation was done	

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A17	Continued From page 12 Since I've been here at this house, we haven't had any training on abuse, neglect, or exploitation that I know of. I would have to look through a book to find out who to call for a phone number. I don't really know where to look. Everything I got at [name of house 1] was just brought over with me." C. On 10/12/06 at 12:45 p.m., during review of Incident Management System Guidelines under section 7.1.13.10 B Training Curriculum, the Administrator stated, "They [the employees] get a whole packet to take home, the managers go through it with them and they take a quiz. We tell them, take the packet home, if you have any questions, you need to ask me." 1. The administrator provided a copy of the documents "Training Curriculum of Abuse, Neglect, and Exploitation" the facility was using and stated, "This is what we got from you guys at APS." The Administrator further explained the training program by stating that all the staff did as far as checking things was get a copy of their license and social security card and we go through the training packet. She said "this is what we use as our training curriculum, emergency action procedures, and how to respond to Abuse, and Neglect." 2. Review of that information given to new employees revealed that a training program from New Mexico Children Youth and Families Department (CYFD), Adult Protective Services (APS) was utilized, not the Department of Health Incident Management System. 3. Review of the training curriculum revealed that the following requirements were missing: (a) an overview of the potential risk of abuse, neglect, misappropriation of consumers' property; (b) informational procedures for properly filing the division's incident management report form; (c)	A17 C-1 C 2,3) C-4.	On 10/23/06 ~~the~~ the employeds got the packet during the inservice we got through at that time, the employee's are told to go home and review the packet and if they have any questions to come to me and ask me. The abuse, neglect, exploration packets are change with both APS & DOH information. We have retrained everyone with update packets and all new employee will have packet within guideline by department and every 6 mo after that I stated to the inspector that inservice was followed from house to house!	

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A17	Continued From page 13 specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and misappropriation of consumers' property. (d) specific instructions on how to respond to abuse, neglect, misappropriation of consumers' property; (e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers' property; and (f) All current employees shall receive training within ninety (90) days of the effective date of this rule. (g) All new employees shall receive training within thirty (30) days of the employees initial hire date. Based on those requirements, no one in the facility had current abuse, neglect and exploitation training. 4. The Administrator further confirmed that the incident management training received by the staff was provided at a different licensed facility. She said, "The Manager, Assistant Manager, and employees #3, 4, 5 and 6 all got their training at [name of other licensed facility] and we've just been transferring what they had over there from home 1 to here at this facility." She indicated that she was not aware that each facility should provide its own training. D. On 10/12/06 at 2:00 p.m., during an interview, the Administrator was asked, "Do you have a definition of what the Federal definitions of Abuse, and neglect are?" The Administrator stated, "This is what I go by (referring to the CYFD/APS training manual). It says step-by-step what abuse is and what neglect are." Review of the information provided did not reveal definitions of abuse, neglect and exploitation or misappropriation of funds. E. On 10/20/06, employee personnel files for Employees #7 and 8 were reviewed. Employee	A17	She stated no they start over at new hire I told her I would update at once. And from now on every one would be treated as a new employee. E) Employee #7, #8 started on 10/12/06, 10/14/06 and all training will be done by 30 day as per guidelines. 11/12/06 f) The abuse, neglect and exploration was done on 10/23/06 for the first time at this home 10/23/06 In the future we will treat all employee's like they are new & training will be done within the guideline of the department. Employee chart will	

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A17	Continued From page 14 #7 was hired on 10/12/06. No documentation of an orientation was in the personnel file. Employee #8 was hired on 10/14/06. No documentation of an orientation was in the personnel file. F. On 10/20/06 at 8:00 a.m., during an interview, the Manager stated, "I came here August 8, 2006 and all my trainings were transported form house I. The abuse, neglect was done at the other house. I haven't had any trainings while I've been "	A17	be reviewed every 3 months. basis.	
A21	7 NMAC 8.2.21 ADMISSION RECORDS 7.8.2.21 ADMISSION RECORDS: A. In addition to the resident record requirements, the facility must maintain for each resident, the following: B. The resident's written acknowledgement that the facility, prior to or at the time of admission, provided the resident with, and answered any resident questions regarding: (1) The facility's program narrative. (2) The facility's rules. (3) The facility's admission agreement, including costs and charges, refund provision, and termination policies. (4) The facility's bed hold policy. (5) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. Such law includes: Uniform Health Care Decisions Act, Section 24-7A-1 et. seq., NMSA 1978, as amended; New Mexico Durable Power of Attorney for Health Care Decisions, Section 45-5-501, et.seq., NMSA 1978, as amended; New Mexico Living Will and Declaration under the Right to Die Act Section 24 -7-1 et seq., NMSA 1978, as amended.	A21		

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A21	Continued From page 15 [4-7-97, 7.8.2.21 NMAC - Rn, 7 NMAC 8.2.21, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7 NMAC 8.2.21(5) Based on record review and interview the facility failed to ensure 3 of 11 residents (#1, 3 and 10) admission records contained information about the resident's right under New Mexico Law to make decisions regarding advance directives. The facility also failed to ensure employees knew which residents had advance directives and what those directions were. The findings are: A. On 10/10/06 at 2:00 p.m., review of Resident #1's chart revealed that the resident was admitted to the facility on 8/12/06, and no documentation of advanced directives was located in the chart. Review of the resident's care plan did not indicate anything under "Advanced Directive" or "DNR Order." Both of these items were left blank. Review of the resident's Admission record did not reveal "yes" or "no" noted under "Advanced Directive (PSDA) on File. B. On 10/10/06 at 2:25 p.m., during an interview, the Assistant Manager was asked, "How would your staff know if a resident was a DNR/DNI or a Full Code?" The Assistant Manager stated that they would not know. She said they would just treat the resident as a full code. C. On 10/10/06 at 2:27 p.m., during an interview, the Administrator stated that they were still in the process of getting papers filled out with the family of Resident #1. She said, "The advance directives were to be in writing, but that the resident's chart was not even put together. What is in here is what we've got."	A21	A) Resident #1 Advance directive was in her Chart. It was a copy from the nursing home. B) The Rule if we do not have a DNR/DNI or Advance directive is that you treat them as full code unless told by family otherwise which has to be stated in notation with signature. C) my statement was we are still working with some family members for the paperwork. Resident #1 paperwork was not complete was waiting for doctor visit to get updated meds and care instruction which was on 10/25/06. D) Resident #10 on 7/24/06 Resident #10 had a physician packet filled out stating she is a DNR/DNI. E) Resident #3 the family has been given the DNR paperwork to be filled out by the doctor and is working on that issue. In the future.	

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A21	Continued From page 16 D. On 10/10/06 at 3:45 p.m., review of Resident #10's record revealed an admission date of 8/10/06 but no information on advanced directives or code status was present. E. On 10/13/06 at 7:40 a.m., review of Resident #3's chart revealed an admission date of 8/9/06. The initial application area under code status was blank. The resident care plan also did not indicate an Advanced Directive or DNR Order. No advanced directive documentation was located in the chart. F. On 10/13/06 at 7:40 a.m., during an interview, the Assistant Manager confirmed the absence of advance directives. She said the information was supposed to be in front of the chart. She said staff are just told to "look in the books, but the front is where you would expect to see something like an advanced directive." G. On 10/20/06 at 9:30 a.m., during an interview, the administrator stated that the advanced directives were mentioned in the admission packet, "But as far as a policy, I don't think we have one." On 10/20/06 at 9:35 a.m., during an interview regarding a policy for Advanced Directives, the facility Corporate office representative stated, "What we have is a POLST form which is a Physician Order for Life Saving Treatment, basically a physicians order for a Do Not Resuscitate/Do Not Intubate (DNR/DNI). We have it for all our other states but for some reason I'm not showing that for New Mexico." H. Review on 10/20/06 of the facility's Admission Agreement revealed the following statement: In the event of an emergency,...all medical professionals will have access to the Advanced	A21	we will keep a closer eye on how long family takes to return the documentation handed to them. f) The advance directive is put in the doctor order and or code status which is back to back in charts. G) we have received the POLST from the main office and is putting the form with all records signed from the residents doctors. In the future we management will be keeping a closer eye to make sure families bring paper work in before deadline date within guidelines of the department.	

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A21	Continued From page 17 Directives and/or Living Wills. I. Review on 10/20/06 of the Resident Admission Packet revealed the following statement: If a resident wishes information on Advanced Directives, the Ombudsman will call. Regulations require that the facility have information available to residents, in accordance with Uniform Health Care Decisions Act, Section 24-7A-1 et. seq., NMSA 1978, as amended; New Mexico Durable Power of Attorney for Health Care Decisions, Section 45-5-501, et.seq., NMSA 1978, as amended; New Mexico Living Will and Declaration under the Right to Die Act Section 24-7-1 et seq., NMSA 1978, as amended, Delegation of that requirement to the Ombudsman program is not allowed.	A21	1) With residents Advance directive is available if the family and doctor have given us the documents that they have received. In the future we will have the documentation in Residents charts within the guidelines provided by the department.	
A22	7 NMAC 8.2.22 RESIDENT RECORDS 7.8.2.22 RESIDENT RECORDS: A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include: (1) Admission records as set out in Section 7.8.2.21 NMAC: (2) Within five (5) days of admission: (a) An executed admission agreement. (b) A completed resident assessment form. (c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an acute care hospital, the hospital history and physical report, and the hospital discharge	A22		

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A22	Continued From page 18 summary may serve as an admission physical. (d) Names, addresses, relationship, and phone numbers of family members, and where appropriate, guardians, agents, and any surrogate decision makers. (3) Within thirty (30) days of admission: (a) A admission physical examination report by a licensed health care professional if an examination report was not available within five (5) days of admission. (b) Resident's name, age, recent photograph, social security number, marital status, date of birth, sex, address prior to admission, religion (optional), personal physician, dentist, social history and designated representative or other emergency contact person, language spoken and understood, legal documentation relevant to commitment and/or guardianship status, present medications, and diet required. (c) Any amendments to the admission agreement. (d) The current completed resident assessment form. (e) A completed and current individual service plan. (f) Entries by direct care staff, appropriate health care professionals, or others authorized to care for the resident. Entries shall be dated and signed by the person making the entry and shall include significant information related to the individual service plan. (g) Entries providing a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention, and entries reflecting appropriate follow-up. The maintenance of such written record in the	A22		

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A22	Continued From page 19 resident record may be by copy of an incident/accident report, if the original incident/accident report is maintained elsewhere by the facility. (h) A medication record: Medications administered by licensed personnel and/or staff assisting with medications to include: listing all currently ordered medications by name, dosage, administration times; documenting by medication name, dosage, date, and time, each medication administered, with the initials of the individual who administered or assisted with the medication; documentation of errors, omissions, and side-effects of medications; and written consent by resident or guardian for staff to assisting with medications. (i) Date, time and progress note of health services provided by any contract agency. (j) Unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures. (k) Transfer forms completed, signed, and provided to accepting facility when resident is transferring to a hospital or another health care facility. (l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care facility, upon death or transfer. B. RESIDENT RECORDS, MAINTENANCE: (1) Resident records shall be maintained and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy for maintaining, and confidentiality of resident records, including the authorized release of resident records.	A22		

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A22	Continued From page 20 (3) Resident records must be maintained by the facility against loss, destruction, and unauthorized use for a period of not less than three (3) years from the date of discharge. (4) There must be a policy and procedure in place for record retention in the event of facility closure. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 7.8.2.22 NMAC - Rn 7 NMAC 8.2.22, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7 NMAC 8.2.22 A(2)(c) Based on record review and interview, the facility failed to have a current history and physical for 2 of 10 residents (#1 and 3). The findings are: A. On 10/10/06 at 2:00 p.m., review of Resident #1's chart revealed that the resident was admitted to the facility on 8/12/06. The last history and physical located in the chart was dated 3/13/05, which was prior to the facility opening. There was no update noted on that document after the admission date. Further review of the chart revealed no diagnosis listed on the resident care plan, no physical assessment, or admission record. B. On 10/10/06 at 2:45 p.m., during an interview, the administrator stated, "The resident's chart is not even put together yet. We were going on what the family was telling us which was to go by the documentation from when she was in the nursing home. What is in here is what we got." C. On 10/13/06 at 7:30 a.m., review of Resident #3's chart revealed no documentation of a current history and physical. The resident was admitted	A22 A)	Resident #1 had a doctor appt on 10/25/06 to update all records we where going on the nursing home order for the physician orders until then. The admission packet was was signed on 8/12/06 nursing assessment was done on 8/24/06 Geriatric Associates PC did a H&P on 8/22/06 that shows diagnosis which list CAD, HTN, DLP, depression. In the future the documentation from previous facility will be reviewed And all other documentation will be done per guideline by the department. B) The statement made was the family stated	

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A22	Continued From page 21 to the facility on 8/9/06. On 10/13/06 at 7:40 a.m., during an interview regarding a current history and physical, the assistant manager stated, "Ideally you would expect to see it right here in front of the chart but it isn't here." Refer to 7 NMAC 8.2.22(A)(3)(b) Based on record review and interview, the facility failed to have current photographs for 6 of 11 residents (#1, 2, 3, 4, 5 and 6). The findings are: A. On 10/10/06 at 2:00 p.m., during record review of Residents' #1-6 charts, it was noted that none of these residents records contained a current photograph. That same day at 2:30 p.m., during an interview, the Administrator confirmed that there were no photographs of the residents. She said, "We haven't been doing those. I wasn't aware we were supposed to have those." Refer to 7.8.2.22 A(3)(g) Based on record review and interview, the facility failed to provide a written account of all accidents and injuries that directly affected 1 of 10 residents (#1). This deficient practice had the potential of affecting all residents. The findings are: A. On 10/19/06 at 12:33 p.m., during an interview, a family member of Resident #1 alleged that facility staff neglected the resident. She stated the resident moved in on 8/12/06, and the next morning the manager called to report that the resident was found lying on the floor in her room and probably had been there the entire night. The family member further stated, "They were supposed to be checking on her every 30	A22	go by the nurse and home doctor ordered her appt. on 10/25/06 Resident #3 MBP is being done by physician we are working with their doctors office In the future we will stay on doctor office to comply with states guidline of 1 mnt. A) The Photographs of all residents was done ASAP after the inspector brought it to my attention it was an oversight 10/23/06 on my part. The pictures was done within three days of inspection On the future during the move in paper work being done the pictures will be done so no oversight will happen	

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	2106	A. BUILDING _____ B. WING _____	C 10/20/2006

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A22	Continued From page 22 minutes; that was in the contract." The family member reported that the resident told her she had spent the whole night on the floor; no one helped her, and she was cold. The family member also said that when the administrator was asked about this, the administrator said that Staff #6 checked on her every 30 minutes and reported on the documentation at 6:30 a.m. when he left that the resident was in bed. B. Review on 10/19/06 of Resident #1's entire chart revealed no documentation of this incident that allegedly occurred on 8/13/06. Additionally, no facility incident report was located. Based on review of the intake database on 10/19/06, no report was made to the state agency regarding the alleged neglect.	A22	I did a internal investigation on the alleged neglect and spoke with the night shift employee, The documentation states the time he was in there working with her, The manager statment was that Resident 1 told her before we checked the facts. After words the administrator told family what was found out. B) There where no report made to the hotline CA DOH due to no finding of neglect or abuse done by employee Resident #1 was trying to get her kids to take her home to her house she built.	
A23	7 NMAC 8.2.23 FAC. REPORTS,RECS.,P & PS & RULES 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND PROCEDURES/ AND RULES: A. REPORTS AND RECORDS: Each facility must keep the following reports, records, and policy and procedures on file at the facility and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or appeals thereto, and complaints. (3) Copy of the latest survey from Environmental Health Authority (if applicable)	A23		

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A23	Continued From page 23 regarding kitchen and food management and, if private sewage disposal, and private waste disposal. EXCEPTIONS: Adult residential care facilities with three (3) or fewer residents are not required to be inspected by Environmental Health Authority. Facilities exempted by the Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file. (4) TB test results of staff or any of their family members living in the facility. (5) One (1) month of menus planned and as served. (6) Record of fire drills: A record of all fire drills conducted at the facility. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to hold or record fire drills. (7) Written emergency plans and policies and procedures for medical emergencies, power failure, fire or natural disaster. Such plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes and refuge areas, responsibilities of personnel. (8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC). (9) Custodial Drug Permit: A valid Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit. (10) Vaccination of pets in the facility. (11) Staff training. (a) At orientation and on-going. (b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...)	A23	On a future we will comply with Reporting when there is abuse, neglect or exploration.	

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A23	Continued From page 24 (c) Fire safety. (d) First aid. (e) Safe food handling practices. (f) Confidentiality of records and resident information. (g) Infection control (including universal precautions and linen handling). (h) Resident rights. (i) Providing Quality Resident care based on current resident need. (j) Reporting requirements for Abuse, Neglect or Exploitation. (12) A copy of License. (13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions. (14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority. (15) A copy of the floor plans as approved for licensure. B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to but not limited to the following: (1) The use of tobacco and alcohol. (2) The use of the telephone. (3) Operation of television, radio, and stereo. (5) Use and safekeeping of personal property. (6) Meals. (7) Use of common areas. (8) Electric blankets or appliances used by residents. C. POLICIES AND PROCEDURES: All facilities shall have written policies and procedures covering the following areas: (1) Actions to be taken in case of	A23		

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A23	Continued From page 25 accidents or emergencies, (e.g., gas leaks, injuries, transportation, medications,...). (2) Method of keeping informed when residents go outside of the facility (e.g., sign-out sheets). (3) The handling or resident's funds, if the facility provides such services. (4) Reporting of incidents, including abuse, neglect, and exploitation. (5) Handling of complaints. (6) Staff and resident fire and safety training. (7) Smoking. (8) The facility's bed hold policy. (9) Admission agreement. (10) Admission records. (11) Resident records. (12) Program Narrative. (13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (14) Personnel policies. (15) Identifying and safeguarding resident possessions. (16) Securing medical assistance if a resident's own physician is not available. (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles. (19) Staff training for employees who operate motor vehicles to transport residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86,	A23		

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A23	Continued From page 26 1-11-90, 4-7-97; 7.8.2.23 NMAC - Rn & A 7 NMAC 8.2.23, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7 NMAC 8.2.23(C)(1)(4)(13)(19) Based on record review and interview the facility failed to follow its policy and procedures for 1) actions to be taken in case of accidents or emergencies; and 2) ensuring staff received training on Incident Management requirements for Reporting Abuse, Neglect, and Exploitation. The facility also failed to develop written policy and procedure or information 1) on the right to make advanced directives; and 2) ensuring staff received training for operating motor vehicles to transport residents. Failure to develop and/or implement facility policy resulted in the death of Resident #1 and had the potential to affect all other residents in the facility (#2-11). The findings are: A. During a complaint investigation conducted from 10/10/06-10/20/06, it was confirmed that an automobile accident occurred on 10/9/06. Resident #1 was killed after not being properly secured in her wheelchair while being transported in the facility transportation van by Caregiver #4. Additionally, Caregiver #4 did not seek 911 assistance or proceed to the local hospital to obtain medical help for the resident. (See tag 7 NMAC 8.2.13(B)(1)(6)(9 and Office of Medical Investigator reports for corroborating details) B. Review of the facility's Adult Residential Care House Rules dated 8/22/99 (prior to the facility's opening) read as follows: "O. The following procedure will be followed in the event of a serious illness or death of a resident: The responsible staff member will call the 911	A23	Caregiver #4 Read the ~~Policy~~ Friday and right Caregiver #4 Knew that Bee Hive Policy was to call 911 or go to the local hosp which the accident was at or near the hospital. 10/19/06 A) On the future only properly trained management employee will provide transportation B) The Caregiver panicked and did not follow the policy of Bee Hive Homes which Resulted in her release of the patient. The report was done on 12/17/06 with what little information I knew at that time. On the future we will be reporting within 24 hrs per-	

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A23	Continued From page 27 emergency number or coroner. The staff member will then call the Administrator... The staff member will supply the arriving emergency medical personnel with the resident's records including any advanced directives." C. Review of the facilities Incident and Complaint Policy dated 5/25/01 (prior to the facility's opening) read as follows: [Name of the facility] will ensure all suspected cases of known incident of resident abuse, neglect...are reported. [The facility] will also report... to the Licensing Authority and Adult Protective Services (APS) by the next business day. In no instance will [the facility] delay a report. All incidents and/or complaints will be brought to the attention of the Administrator. All problems will be documented in writing." Review on 10/10/06 of the intake database did not reveal a report to the licensing authority. That lack of a report was confirmed by the administrator on 10/12/06 at 2:00 p.m. during an interview. D. Review of the facilities Resident Admission Agreement revealed the following statement: all medical professionals will have access to the Advanced Directives and/or Living Wills. 1. On 10/10/06 at 2:00 p.m., review of Resident #1's chart revealed that the resident was admitted to the facility on 8/12/06, and no documentation of advanced directives was located in the chart. Review of the resident's care plan did not indicate anything under "Advanced Directive" or "DNR Order." Both of these items were left blank. Review of the resident's Admission record did not reveal "yes" or "no" noted under "Advanced Directive (PSDA) on File. 2. On 10/10/06 at 2:27 p.m., during an interview, the administrator stated that they were	A23	guideline of the department even if the ~~employee~~ information available at the time 10/20/06 is incomplete. 2) The advance directive was in residents file in the section with other nursing home paperwork, we still had a list of staff we needed at time of death from the family 3) Resident #10 has a doctor assessment signed 7/24/06 with DNR/DNI as her code status. 4) Resident #3 family is working on her DNR/DNI. The paperwork will be in her chart before 12/30/06. In the future the staff will keep a closer eye on nursing	

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A23	Continued From page 28 still in the process of getting papers filled out with the family of Resident #1. She said, "Advance directives were to be in writing, but that the resident's chart is not even put together. What is in here is what we've got." 3. On 10/10/06 at 3:45 p.m., review of Resident #10's record revealed an admission date of 8/10/06 but no information on advanced directives or code status was present. 4. On 10/13/06 at 7:40 a.m., review of Resident #3's chart revealed an admission date of 8/9/06. The initial application area under code status was blank. The resident care plan also did not indicate an Advanced Directive or DNR Order. No advanced directive documentation was located in the chart. 5. On 10/13/06 at 7:40 a.m., during an interview, the Assistant Manager confirmed the absence of advance directives. She said the information was supposed to be in front of the chart. She said, "Staff are just told to look in the books but the front is where you would expect to see something like an advanced directive." 6. On 10/20/06 at 9:30 a.m., during an interview, the Administrator stated that the advanced directives were mentioned in the admission packet, "But as far as a policy, I don't think we have one." On 10/20/06 at 9:35 a.m., during an interview regarding a policy for Advanced Directives, the facility Corporate office representative stated, "What we have is a POLST form which is a Physician Order for Life Saving Treatment, basically a physicians order for a Do Not Resuscitate/Do Not Intubate (DNR/DNI). We have it for all our other states but for some reason I'm not showing that for New Mexico."	A23	forms and stop within the guideline of the department. 5) The advance directive is in the code status section of the resident chart. Unless they come on from a Hospital or Nursing Home setting then it is in the Misc Section On the future we will keep all code status paperwork in code status section so there is no misunderstanding.	
A30	7 NMAC 8.2.30 TRANSPORTATION 7.8.2.30 TRANSPORTATION: Each facility	A30		

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A30	Continued From page 29 licensed pursuant to these regulations must either provide safe transportation or assist the resident in using public transportation. A. The motor vehicle transportation assistance program shall be comprised of but not limited to the following elements: (1) Client assessment, emergency procedures, supervised practice in the safe operation of motor vehicles, familiarity with state regulations governing the transportation of persons with disabilities, maintenance and safety, record keeping, training on hazardous driving conditions and a method for determining and documenting successful completion of the course. (2) The course requirements above are examples and may be modified as needed. B. To assist residents in using transportation, the facility must be able to provide information on bus schedules, location of bus stops, and telephone numbers of taxi cab companies. [7-11-86, 1-11-90, 4-7-97; 7.8.2.30 NMAC - Rn & A 7 NMAC 8.2.30, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7 NMAC 8.2.30(A)(1); and (B) Based on record review and interview, the facility failed to ensure that all employees who assist with transportation of residents attended a Motor Vehicle Transportation Assistance Program. The facility also failed to ensure that staff were properly trained and qualified in the overall safety and function of the facility transportation van. No assessment or observation of driving skills was conducted. This failure was a contributing factor which led to the death of 1 of 11 residents (#1). The findings are:	A30		

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A30	Continued From page 30 A. During a complaint investigation conducted from 10/10/06-10/20/06, it was confirmed that an automobile accident occurred on 10/9/06. Resident #1 was killed after not being properly secured in her wheelchair while being transported in the facility transportation van by Caregiver #4. Additionally, Caregiver #4 did not seek 911 assistance or proceed to the local hospital to obtain medical help for the resident. 1. On 10/10/06 at 11:00 a.m., during an interview, the facility Administrator stated that the accident on 10/9/06 which resulted in the death of Resident #1 was the first time that Caregiver #4 had transported a resident in the facility van. She said that she worked with her prior to her leaving with the resident. She said, "I told her [Caregiver #4], let's go through things and make sure you know how to operate the van. I asked her, 'You know how to operate the van right?' She said that she had owned a van before and that she knew how to drive it." The administrator then said, "I told her step-by-step what to do, and [Caregiver #4] kept telling me, 'I know, I know what to do.' I demonstrated how to do everything step-by-step, then I had her demonstrate to me." The administrator further explained that on the morning of 10/9/06 she told Caregiver #4 step-by-step, and demonstrated how to to properly secure the resident in the facility transportation van by securing the wheelchair in place as well as properly securing the safety belt. The administrator further stated, "I had to keep reminding her [Caregiver #4] to put her hand on the resident's head so she wouldn't hit her head on the top of the van." Upon arrival to the physician's office, the Administrator stated that again, "I had to remind her about not hitting her resident's head on the van, and also had to remind her about making sure the safety belt was tight. The administrator then stated, the next	A30		

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A30	Continued From page 31 thing she knew she received a call from the Manager saying "I need you to come over here, the resident is bleeding." The administrator stated that upon arrival to the facility, "Resident #1 was lying behind the drivers seat. Her feet were by the drivers seat. Her head was where the wheelchair was supposed to be. She was lying at an angle. I saw her in the van, and she had blood on her head." 2. On 10/10/06 at 11:30 a.m., during an interview with the Owner of the facility, he stated, "According to the EMT she had no pulse and was not breathing." The owner further stated that when he called the family, he stated that "there was an accident, I believe she has died and have reason to believe we were at fault." The Administrator also stated, "There is no way Resident #1 could have gotten out of her wheelchair or even moved herself side-to-side. 3. On 10/10/06 at 12:15 p.m., during an interview with Cook/Employee #2 he stated, "As she [Caregiver #4] came here, her hands were covered in blood. I went outside to the van and it appeared that [Name of resident #1] had hit her head. Her head was facing the seat, she was lying on her back and her head was lying to the side. I shook her a little bit from her legs and said are you okay. She was gurgling. I rolled her on her back to assess her. It appeared that she might have had a petechial hemorrhage to her left eye and a massive laceration to the bridge of her nose." The Employee #2 further stated, "The wheelchair was in the back of the van. I don't believe it was secured in place." 4. On 10/11/06 at 8:32 a.m., during an interview, a Deputy Field Investigator stated, "I was notified at 11:50 a.m. by dispatch. When I got there the body was in the van. But, before that, I stopped at McMahon and Golf Course where the incident occurred and got an	A30		

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A30	Continued From page 32 explanation from the officer what happened. I timed the mileage which was 4.6 miles." The Field Investigator further stated, "When I arrived on the scene I looked at her [Resident #1]. I was told by EMT that they had already declared her dead. She was in the back of the van around the area where the wheelchair would be. Her legs were stretched toward the front passenger door, and seat. If I'm correct, this would not have happened if she was securely fastened in her wheelchair and if the wheelchair was securely fastened in the van." The Field Investigator further stated, "I checked the seat belt. It had no cuts, rips, or fraying. It was in good shape, and I do not think it was a malfunction. It looked in good shape to me." The Field Investigator stated, "I know her skull separated from her atlas meaning the first vertebrae form her spinal column separated, hense a broken neck. There was a dislocated right shoulder. Based on what it looked like, some lacerations to face, small cuts made by impact... these were Deep Rips. The lower part of her nose, and forehead had blood on it." Also, the console that sat between the two front seats "was all bloody and there was blood on the floor. When I saw her, she was on her back, the head was where the wheelchair would have been and her feet were diagonally towards the back." 5. On 10/11/06 at 12:30 p.m., during an interview, the owner of the facility stated, "She [Caregiver #4] did not lock the apparatus and did not lock the wheelchair. She went down the road the wrong way, then over the median." 6. On 10/11/06 at 1:45 p.m., during a second interview, Employee #2 created a drawing representing the resident's body in location to the van. He stated, "Her head was behind the drivers seat towards the side a little bit. The wheelchair was next to her and I saw one of the rear back	A30 B)	Employee #4 had one on one training Review on 10/9/06. On the future will be the only on transferring any Residents. I have been trained to transport resident and instruct other regarding transportation of Residents. C1) That we use FLI's defensive driving training materials for the transportation of passengers with special needs. C2) We go through Also for the medication and first aid training not transportation training.	

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	2106	A. BUILDING _____ B. WING _____	C 10/20/2006

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A30	Continued From page 33 wheels that was not attached, and kinked to the side. That's how I knew it [the wheelchair] wasn't securely attached to the van." 7. On 10/12/06 at 11:45 a.m., during an interview, the physician who performed the autopsy from Office of the Medical Investigator, stated "the first cervical C1 Vertebrae (Atlantis/Occiput) was dislocated. There was hemorrhaging in the muscle/tissues, the bridge of her nose was fractured, and her skin was torn and lacerated. But what killed her, was the C1 skull separating from her spinal column." B. On 10/12/06 at 12:30 p.m., during an interview, the facility Administrator was questioned regarding the transportation training program and facility policies and procedures regarding training. She stated that they used a workbook. She said that Caregiver #4 had never driven the van before. But she indicated that she went section-by-section with her through this workbook. She said, "We would just talk about things and I would ask her if she had any questions, then we would go through the next page. We never did any dry runs with the van; all it was, was just going through this workbook." C. Throughout the investigation, conflicting information was provided regarding training for transportation. 1. On 10/10/06 at 4:15 p.m., the Administrator was asked, "How do you train your staff regarding safety and properly transporting residents?" The administrator stated, "My staff feel safe with us. We haven't done any training here that much. We've just earned a trust with them." 2. On 10/11/06 at 12:30 p.m., during an interview, the Owner of the facility stated, we get our training through the ALSO Program "Assisted Living Services Organization." The Owner further	A30	C-3) In the future there will not be anyone transporting but myself. D) We assist the family in transportation or call Rio transit In the future if families requested assistance transportation I will be only one transporting.	

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A30	Continued From page 34 stated, "She [Caregiver #4] did not lock the apparatus and did not lock the wheelchair. She went through the training thoroughly on 8/8/06. The training was here and [Name of administrator] did the training. She [Caregiver #4] went down the road the wrong way then went over a median." The owner further commented, "We will transport people in our own cars. What sorts of training would you need to transport someone? It's not rocket science to put someone in the car." 3. On 10/11/06 at 1:10 p.m., during an interview with both the Owner and the Administrator, the Administrator stated, "No, we don't have a ALSO Program. They [ALSO] just do the med training. They have a transportation course you can send people to but we don't participate." When asked, "How do you feel secure that you have a safe driver?" the administrator stated, "Just by a drivers license is all I go by. I mean I had her follow me, that's my way of seeing any bells or alarms that might have gone off at that point." The administrator stated, "No, we don't have a protocol for safety of the van. That's just common sense." The Administrator further stated, "If the State of N.M. is okay to give someone a driver's license, then why should we have to check into it. That just comes with training." D. Review of the facilities policy and procedures Policy Manual dated 5/25/01 read as follows: 1. General Provisions: N. [The facility] has made arrangements to transport residents by way of facility vehicle to a prearranged location should evacuation be required. Review of the facilities Resident Admission Agreement read as follows: [The facility] may arrange transportation as requested for the resident to local medical/dental or other appointments. No other policies were	A30		

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A30	Continued From page 35 available.	A30		
A33	7 NMAC 8.2.33 REPORTING OF INCIDENTS 7.8.2.33 REPORTING OF INCIDENTS: A. The facility must insure that all suspected cases or known incidents of resident abuse, neglect, exploitation, and mistreatment are reported. A facility must also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority and Adult Protective Services (APS) by the next business day. In no instance may a facility delay a report to Adult Protective Services or to the Licensing Authority, while an internal investigation is being conducted. B. The facility is responsible for documenting all incidents, within five (5) days of the incident, and having on file, the following: (1) A narrative description of the incident. (2) Results of the facility's investigation. (3) The facility action, if any. [7-1-64, 9-15-70, 5-26-72, 7-11-86, 4-7-97; 7.8.2.33 NMAC - Rn 7 NMAC 8.2.33, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7 NMAC 8.2.33(A)(B) Cross Refer to 7 NMAC 1.13.8 - Incident Management System Reporting Requirements For Licensed Health Care facilities Also Cross Refer to 7 NMAC 1.13.10 A-F - Incident Management System Requirements Based on observation, record review and interview, the facility failed to: 1) report multiple incidents of neglect, one of which resulted in the death of 1 of 11 Residents (#1), to the Licensing	A33		

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A33	Continued From page 36 Authority within 24 hours; 2) have an Incident Management System in place for reporting incidents of abuse, neglect, and exploitation; and 3) follow the facility's Incident policies and procedures for reporting. The facility also failed to implement a training curriculum for its employees, and also failed to have postings of required Incident Management Posters. The findings are: A. On 10/10/06 at 11:00 a.m., during an interview, the Administrator stated that an incident occurred on Monday 10/9/06 in which Caregiver #4 was transporting Resident #1 to her scheduled physician's appointment. According to the resident's medical record reviewed on 10/10/06, the resident was an 85-year-old who was alert, oriented, able to make her needs known, and who primarily used a wheelchair for ambulation. On the return trip from the physician's office to the facility, Caregiver #4 had a motor vehicle accident in which the resident, who was unrestrained in the wheelchair, was fatally injured. Caregiver #4 made no attempt to call 911 or to drive to the local hospital to seek medical assistance for the resident. Instead, she returned to the facility four miles from the accident site and asked for help there. Resident #1 died as a result of the injuries sustained. 1. The administrator said that on the morning of 10/9/06 she told Caregiver #4 step-by-step, and demonstrated how to to properly secure the resident in the facility transportation van. She said that she had to keep reminding the caregiver to put her hand on the resident's head so she would not hit her head on the top of the van. Upon arrival to the physician's office, the administrator stated that again, "I had to remind her about not hitting her [resident #1's] head on the van, and also had to remind her about making	A33		

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A33	Continued From page 37 sure the safety belt was tight. She confirmed that this was her [Caregiver #4's] first transfer and also the first time driving the transportation van." She indicated that she left the resident with the caregiver. 2. The administrator then stated she got a call from the Manager telling me "I need you to come over here, [the resident] is bleeding." The administrator stated that upon arrival to the facility, "Resident #1 was lying behind the drivers seat. Her feet were by the drivers seat. Her head was where the wheelchair was supposed to be. She was lying at an angle. I saw her in the van, and she had blood on her head." 3. On 10/10/06 at 11:30 a.m., during an interview with the Owner of the facility, he stated that that EMT said she had no pulse. The owner further stated that when he called the family, he stated, "There was an accident, I believe she has died and have reason to believe we were at fault." On 10/10/06 at 11:45 a.m., during an interview, the Administrator stated, "There was no way she could have gotten out of her wheelchair or even moved herself side-to-side." 4. Employee #2 was interviewed because he was the first facility caregiver to provide assistance. On 10/10/06 at 12:15 p.m., during an interview Employee #2 stated, "As she [Caregiver #4] came here, her hands were covered in blood. I went outside to the van and it appeared that [Resident #1] had hit her head. Her head was facing the seat, she was lying on her back and her head was lying to the side. I shook her a little bit from her legs and said are you okay. She was gurgling. I rolled her on her back to assess her. It appears that she may have had a petechial hemorrhage to her left eye and a massive laceration to the bridge of her nose." 5. On 10/11/06 at 7:30 a.m., during an interview the Office of the Medical Investigator	A33		

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A33	Continued From page 38 stated, "An autopsy was conducted yesterday and the cause of death was blunt force injury of neck and partial occipital separation." 6. On 10/11/06 at 8:32 a.m., during an interview, a Deputy Field Investigator stated, "I was notified at 11:50 a.m. by dispatch. When I got there the body was in the van. But, before that, I stopped at McMahon and Golf Course (where the incident occurred) and got an explanation from the officer what happened. I timed the mileage which was 4.6 miles. The Field Investigator further stated, "When I arrived on the scene I was told by EMT that they had already declared her dead. She was in the back of the van around the area where the wheelchair would be. Her legs were stretched toward the front passenger door, and seat. If I'm correct, this would not have happened is she was securely fastened in her wheelchair and if the wheelchair was securely fastened in the van." The Field Investigator further stated, "I checked the seat belt. It had no cuts, rips, or fraying. It was in good shape, and I do not think it was a malfunction. It looked in good shape to me. I know her skull separated from her atlas meaning the first vertebrae form her spinal column separated, a broken neck. There was a dislocated right shoulder. Based on what it looked like, some lacerations to face, small cuts made by impact, these were deep rips. The lower part of her nose, and forehead had blood on it. The console that sat between the two front seats, that was all bloody and there was blood on the floor. When I saw her, she was on her back, the head was where the wheelchair would have been and her feet were diagonally towards the back. 7. On 10/11/06 at 12:30 p.m., during an interview, the Owner of the facility stated, "She	A33		

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A33	Continued From page 39 [Caregiver #4] did not lock the apparatus and did not lock the wheelchair. She went down the road the wrong way, then over the median." 8. On 10/11/06 at 1:45 p.m., during a second interview, Employee #2 drew a representation of the resident's body in location to the van. He stated, "Her head was behind the drivers seat towards the side a little bit. The wheelchair was next to her and I saw one of the rear back wheels that was not attached, and kinked to the side. That's how I knew it [the wheelchair] wasn't securely attached to the van" B. On 10/12/06 at 11:25 a.m., review of the State Central Intake Database for Reporting Incidents verified that no one from the facility had reported the incident to the Department of Health. C. On 10/12/06 at 12:30 p.m., when asked "What is your policy on reporting incidents of abuse, neglect, and exploitation?" the Administrator stated, "Our policy is what I did. I called the 1-800 number and talked to SCI. (State Central Intake). When the surveyor was reviewing the new Incident Management System Guidelines (effective 2/28/06) under section 7.1.13.8 F, Quality Improvement System for Licensed Health Care Facilities, the Administrator stated, "We keep incident reports in the book and the report goes with the Incident report. We just go by what happened. We went from what we learned from House 1, and are learning from those mistakes, and how to prevent them from happening here. So, if something were to happen, we make sure it doesn't happen again." 1. When asked about employee training, the Administrator stated, "They (the employees) get a whole packet to take home, the managers go through it with them and they take a quiz. We tell them, take the packet home, if you have any	A33	B) the report was faxed on 10/17/06 C-1) The abuse, neglect, exploration packet is gone through during the inservice and the employee take the packet home to Review, and if they have any question they are told to come to me C-2) our abuse, neglect and exploitation training has been amended to comply with both APS and DHI standards D) we were waiting to make the report until 10/17/06 we had gathered additional information about the incident, but from now on we will make the Report within the required time frame with as much information	

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A33	Continued From page 40 questions, you need to ask me." The administrator provided a copy of the training curriculum of "Abuse, Neglect, and Exploitation" the facility was using and stated, "This is what we got from you guys at APS." The Administrator further stated, "All we do as far as checking things, is get a copy of their license and social security card and we go through the training packet." 2. Review of the identified "training curriculum" that was given to new employees revealed that the training curriculum the Administrator had was from New Mexico Children Youth and Families Department (CYFD) and Adult Protective Services (APS). The training curriculum was based on community providers through APS, and not the Department of Health Incident Management System. 3. Further review of the "training curriculum" read as follows: "Process for Making Referrals to CYFD Statewide Central Intake 2. Provide all relevant information to the SCI Social Worker..." The Administrator verified, "This is what we use as our training curriculum, emergency action procedures, and how to respond to Abuse, and Neglect." D. On 10/12/06 at 2:00 p.m., during an interview, when asked, "Do you have a definition of what the Federal definitions of Abuse, and Neglect are?" the Administrator stated, "This is what I go by (referring to the CYFD/APS training manual). It says step--step what abuse is, and what neglect are. It describes stress management for the employees to prevent them from getting to the point to where they would commit abuse or neglect." When asked about the incident report regarding the death of Resident #1 that occurred on 10/9/06, the administrator stated, "I still don't	A33	as possible at the time. E) that we will amend our incident and complaint policy to include the requirements listed in (E-4) 1) Requirement that the person with the most knowledge should Report the incident. 2) Requirement to conduct or inform families about abuse, neglect and exploitation. 3) hanging of posters 4) no Requirement to conduct an Investigation 5) no Requirement to Report Investigation to DOH/PHI 6) no Requirement to integrate the finding of the investigation into a quality management system.	

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A33	Continued From page 41 know what to fill out, I don't know what happened. I haven't got a clear understanding of what happened so how would I go about filling this report out." E. Review of the facilities Incident and Complaint Policy (dated 5/25/01) revealed the following statements: 1. Resident Grievance Procedure: Each incident will be documented and investigated... All staff members are encouraged to report any knowledge they may have of wrongful treatment... 2. [The facility] will insure that all suspected cases or known incidents of residents abuse, neglect, exploitation, and mistreatment are reported. [The facility] will also report any incident... that has or could threaten the health, safety, or welfare of the residents to the Licensing Authority... by the next business day. In no instance will [the facility] delay a report... to the Licensing Authority... 3. [The facility] will be responsible for documenting all incidents within five days of the incident... 4. Review of these policies did not reveal 1) a requirement that the person with the most knowledge should report the incident; 2) a requirement to inform residents and families about the abuse, neglect policy and reporting numbers; 3) no requirement to hang posters; 4) no requirement to conduct an investigation; 5) no requirement to report the results of the investigation to the licensing authority; and 6) no requirement to integrate the findings of the investigation into a quality management system. F. On 10/19/06 at 12:33 p.m., during an interview, a family member of Resident #1 alleged that facility staff also neglected the resident on a different occasion. She stated that	A33	f) the documentation on the night in question was in the documentation book and that was handed to the inspector to look through. that was where the internal investigation was also. g) the poster where there and during to process of moving Residents in the poster where taen and thrown away. We replaced one where gotten at the DOH / DHI office. In the future the poster will be up whether in good condition or not H) all staff well and have been retained in the Incident Reporting	

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A33	Continued From page 42 the resident moved in on 8/12/06, and the next morning the manager called to report that the resident was found lying on the floor in her room and probably had been there the entire night. The family member further stated, "They were supposed to be checking on her every 30 minutes; that was in the contract." The family member reported that the resident told her she had spent the whole night on the floor; no one helped her, and she was cold. The family member also said that when the administrator was asked about this, the administrator said that Staff #6 checked on her every 30 minutes and reported on the documentation, at 6:30 a.m. when he left that resident #1 was in bed. Review on 10/19/06 of the resident's entire chart revealed no documentation of this incident that supposedly occurred on 8/13/06. Additionally, no facility incident report was located. Based on review of the intake database on 10/19/06, a report was not made to the state agency regarding the alleged neglect. G. During the entire time of the complaint investigation conducted from 10/10/06-10/20/06 numerous observations revealed no postings of the Incident Management Posters regarding information on reporting Abuse, Neglect, and Exploitation. 1. On 10/12/06 at 12: 45 p.m., during an interview, the administrator stated, "Those should be next to the Ombudsman posters." 2. On 10/12/06 at 4:59 p.m., a fax received from the administrator stated, "Poster are not put up. That is in #1 Home. They fell down and was throwed [sic] away in [name of the facility]." H. On 10/13/06 at 7:20 a.m., observation of the	A33 I)	On the future we will have a document from Staff members stating how to report and to whom to report So there are no more misunderstanding	

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A33	Continued From page 43 facility revealed no Incident Management Posters hanging on the walls or next to the Ombudsman posters. 1. At 7:45 a.m., during an interview, the Assistant Manager stated, "No, I've never seen any posters posted here. I don't even know what they would look like. We haven't had any here that I'm aware of." 2. At 9:00 a.m., during an interview, when asked "How do you as staff know what to report or who to report suspected abuse, neglect to?" the Assistant Manager stated, "I don't know where the Incident Reports are kept, if they fall or need to be sent to the hospital we call [the manager or administrator]." When asked "What do you do if both the manager and administrator are unavailable?" the Assistant Manager then stated, "Honestly, I wouldn't know what to do, I don't know the 1-800 #'s or even where that is. I guess I would just find a Incident form and fill that out the best I could." I. On 10/13/06 at 9:15 a.m., during an interview, the Manager stated, "I haven't seen any posters in here, there isn't any that I know of. Since I've been here at this house, we haven't had no training on abuse, neglect, or exploitation that I know of. I would have to look through a book to find out who to call for a phone number. I don't really know where to look."	A33		
A34	7 NMAC 8.2.34 RESIDENT RIGHTS 7.8.2.34 RESIDENT RIGHTS: All licensed facilities shall be aware of, protect, and enhance the rights of all residents. A. Prior to admission to a facility, a resident and/or legal representative shall be given a written description of the legal rights of the residents translated into another language, if	A34		

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A34	Continued From page 44 necessary, to meet the residents understanding. B. If the resident is incapable of understanding his/her legal rights, and if he/she has no legal representative, then the licensee shall also give a written copy of the resident's legal rights to one of the following persons, in this order of priority: (1) the resident's spouse; (2) any of the resident's adult children; (3) either of the resident's parents; (4) any relative the resident has lived with for six or more months before admission; (5) a person who has been caring for, or paying benefits on behalf of the resident; (6) a placing agency; or (7) any other person, e.g., Ombudsman. C. These resident rights and the telephone number for the Ombudsman Program shall be posted in a conspicuous place in the facility: D. The facility, to protect resident rights must: (1) Treat all residents with courtesy, respect, dignity and compassion. (2) To the extent that resident required services fall within the scope of the facilities program, avoid discrimination in admission or services because of a resident's age, race, religion, physical or mental disability, or nationality. (3) Furnish residents written information about all services provided by the facility and their costs, and advance written notice of any changes. (4) Assure that residents have a safe and sanitary living environment. (5) Provide humane care. (6) Assure the resident's rights to privacy in medical care, including privacy during medical examinations, consultations and treatment; and protect the confidentiality of the resident	A34		

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A34	Continued From page 45 medical records. (7) Protect and assure the resident's 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. (8) Assure the resident's right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and assure the resident's right's to receive visits from family, friends, lawyers, ombudsmen and community organizations. (9) Prohibit the use of any and all physical and chemical restraints. (10) Assure the residents are free from physical and emotional abuse and neglect. (11) Assure that all residents are free from financial abuse and exploitation by facility staff and/or management. (12) Consistent with the resident's health, abilities and security, assure the right of the resident to freely participate in religious, social, community and other activities; and freely associate with persons in and out of the facility. (13) Permit the residents to leave the facility freely and return without unreasonable restriction. (14) Prevent unjustified room transfers or discharge from this facility. (15) Use care and management practices that foster social interaction and avoid practices that unnecessarily result in social isolation. (16) Provide services consistent with informed consent. (17) Assure that all residents may voice grievances to the facility staff, public officials, the ombudsmen or any other person, without fear of reprisal or retaliation.	A34		

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A34	Continued From page 46 (18) Promptly address and resolve resident complaints. (19) Foster resident participation and understanding in the development, review and modification of the resident's plan for care and treatment. (20) Respect a resident's choice of doctor, pharmacist and other health care provider. (21) Respect a resident's medical treatment decisions and advance directives, such as living wills and durable powers of attorney for health care. (22) Respect a resident's right to keep and use personal possessions without loss or damage. (23) Allow each resident to manage and control the resident's personal finances to the extent that the resident is able, and provide to every resident a written record of all financial arrangements and transactions involving that resident's funds. (24) Allow residents to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management. (25) Require no resident to work for the facility. (26) Consult with the incapacitated resident regarding his/her care, regardless of the involvement of a guardian or surrogate decision maker. (27) Assure the involvement in, and consent of, an incapacitated resident's guardian or surrogate decision maker in the resident's care. E. The resident's rights shall not be restricted unless the resident agrees to such a restriction, and unless this restriction is described in detail in his/her individual service plan.	A34		

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A34	Continued From page 47 [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.34 NMAC - Rn, 7 NMAC 8.2.34, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7 NMAC 8.2.34(D)(10) Based on record review and interview, the facility failed to protect 1 of 11 residents (#1) rights to a safe environment and to ensure the safety of that resident while being transported in the facility transportation van by an untrained and unqualified employee. This neglect resulted in the death of Resident #1. The findings are: A. During a complaint investigation conducted from 10/10/06 through 10/20/06, it was confirmed that an automobile accident involving the facility van occurred on 10/9/06. Resident #1, the sole resident occupant, was killed after not being properly secured in her wheelchair while being transported by Caregiver #4. Additionally, Caregiver #4 did not seek 911 assistance or proceed to the local hospital to obtain medical help for the resident. The facility did not provide adequate training or supervision for the caregiver as evidenced below: 1. On 10/10/06 at 11:00 a.m., during an interview, the facility Administrator stated that the accident on 10/9/06 which resulted in the death of Resident #1 was the first time that Caregiver #4 had transported a resident in the facility van. She said that she worked with the caregiver prior to her leaving with the resident. She said, "I told her, [Caregiver #4], let's go through things and make sure you know how to operate the van. I asked her, 'You know how to operate the van right?' She said that she had owned a van before and that she knew how to drive it." The administrator then said, "I told her step-by-step what to do, and [Caregiver #4] kept telling me, 'I	A34 A1)	Caregiver #4 was giving the training on calling 911 and Resident Rights and transportation workbook Caregiver #4 had a review on 10/9/06 before she took Resident 1 to her appt. Caregiver #4 was done fine when she demostrated the Procedure of transporting of a resident.	

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A34	Continued From page 48 know, I know what to do.' I demonstrated how to do everything step-by-step, then I had her demonstrate to me." The administrator further explained, "On the morning of 10/9/06 I told Caregiver #4 step-by-step, and demonstrated how to to properly secure the resident in the facility transportation van by securing the wheelchair in place as well as properly securing the safety belt. a. The administrator further stated, "I had to keep reminding her [Caregiver #4] to put her hand on the resident's head so she would not hit her head on the top of the van." b. Upon arrival at the physicians office, the administrator stated that again, "I had to remind her about not hitting the resident's head on the van. I also had to remind her about making sure the safety belt was tight." c. The administrator confirmed that she left Resident #1 alone with Caregiver #4. d. The administrator then stated, the next thing she knew she received a call from the Manager saying "I need you to come over here, the resident is bleeding." The administrator stated that upon arrival to the facility, "Resident #1 was lying behind the drivers seat. Her feet were by the drivers seat. Her head was where the wheelchair was supposed to be. She was lying at an angle. I saw her in the van, and she had blood on her head." 2. On 10/10/06 at 11:30 a.m., during an interview with the Owner of the facility, he stated that according to the EMT she had no pulse and was not breathing. The owner further stated that when he called the family, he stated "There was an accident, I believe she has died and have reason to believe we were at fault." The Administrator also stated that there was no way the resident could have gotten out of her wheelchair or even moved herself side-to-side.	A34		

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A34	Continued From page 49 3. On 10/10/06 at 12:15 p.m., during an interview with Employee #2 he stated that, "As she [Caregiver #4] came here, her hands were covered in blood. I went outside to the van and it appeared that [Name of Resident #1] had hit her head. Her head was facing the seat, she was lying on her back and her head was lying to the side. I shook her a little bit from her legs and said are you okay. She was "gurgling." I rolled her on her back to assess her. It appeared that she might have had a petechial hemorrhage to her left eye and a massive laceration to the bridge of her nose." Employee #2 further stated, "The wheelchair was in the back of the van. I don't believe it was secured in place." 4. On 10/11/06 at 8:32 a.m., during an interview, a Deputy Field Investigator stated, "I was notified at 11:50 a.m. by dispatch. When I got there [to the facility] the body was in the van. But, before that, I stopped at McMahon and Golf Course where the incident occurred and got an explanation from the officer about what happened. I timed the mileage which was 4.6 miles. The Field Investigator further stated, "When I arrived on the scene I looked at her [Resident #1]. I was told by EMT that they had already declared her dead. She was in the back of the van around the area where the wheelchair would be. Her legs were stretched toward the front passenger door, and seat. If I'm correct, this would not have happened if she [Resident #1] was securely fastened in her wheelchair and if the wheelchair was securely fastened in the van." a. The Field Investigator further stated, "I checked the seat belt. It had no cuts, rips, or fraying. It was in good shape, and I do not think it was a malfunction. It looked in good shape to me." b. The Field Investigator stated, "I know her	A34		

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A34	Continued From page 50 skull separated from her atlas meaning the first vertebrae form her spinal column separated, hense a broken neck. There was a dislocated right shoulder. Based on what it looked like, some lacerations to face, small cuts made by impact. . . these were deep rips. The lower part of her nose, and forehead had blood on it." Also, the console that sat between the two front seats was all bloody and there was blood on the floor. When I saw her, she was on her back, the head was where the wheelchair would have been and her feet were diagonally towards the back. 5. On 10/11/06 at 12:30 p.m., during an interview, the owner of the facility stated, "She [Caregiver #4] did not lock the apparatus and did not lock the wheelchair. She went down the road the wrong way, then over the median." 6. On 10/11/06 at 1:45 p.m., during a second interview, Employee #2 drew a representation of the residents body in location to the van. He stated, "Her head was behind the drivers seat towards the side a little bit. The wheelchair was next to her and I saw one of the rear back wheels that was not attached, and kinked to the side. That's how I knew it wasn't securely attached to the van." 7. On 10/12/06 at 11:45 a.m., during an interview, a Physician (who performed the autopsy) from Office of the Medical Investigator, stated, "The first cervical C1 Vertebrae (Atlantis/Occiput) was dislocated. There was hemorrhaging in the muscle/tissues, the bridge of her nose was fractured, and her skin was torn and lacerated. But what killed her, was the C1 skull separating from her spinal column." B. On 10/12/06 at 12:30 p.m., during an interview, the facility Administrator was questioned regarding the transportation training program and facility policies and procedures	A34		

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A34	Continued From page 51 regarding training. She stated that they used a workbook. She said that with Caregiver #4, "She had never driven the van before." But she indicated that she went section by section with her through this workbook. "We would just talk about things and I would ask her if she had any questions, then we would go through the next page. We never did any dry runs with the van; all it was, was just going through this workbook." C. From 10/20/06 through 10/20/06, throughout the investigation, conflicting information was provided regarding transportation training for employees. 1. On 10/10/06 at 4:15 p.m, when "How do you train your staff regarding safety, and properly transporting residents?" the administrator stated, "My staff feel safe with us, We haven't done any training here that much. We've just earned a trust with them." 2. On 10/11/06 at 12:30 p.m., during an interview, the Owner of the facility stated, "we get our training through the ALSO Program [Assisted Living Services Organization]." The Owner further stated "She [Caregiver #4] did not lock the apparatus and did not lock the wheelchair. She went through the training thoroughly on August 8, 2006. The training was here and [the administrator] did the training. She [Caregiver #4] went down the road the wrong way then went over a median." The owner further stated, "We will transport people in our own cars. What sorts of training would you need to transport someone. Its not rocket science to put someone in the car." 3. On 10/11/06 at 1:10 p.m., during an interview with both the Owner and the Administrator, the Administrator stated, "No, we don't have a ALSO Program. They just do the med training. They have a transportation course you can send people but we don't participate."	A34		

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A34	Continued From page 52 When asked "How do you secure that you have a safe driver?" the administrator stated, "Just by a drivers license is all I go by. I mean I had her follow me, that's my way of seeing any bells or alarms that might have gone off at that point." The administrator stated, "No, we don't have a protocol for safety of the van. That's just common sense." The Administrator further stated, "If the State of N.M. is okay to give someone a drivers license, then why should we have to check into it. That just comes with training." D. The personnel file of Caregiver #4 was reviewed an on 10/10/06 at 11:45 am and a written warning dated August, 2006, was noted in the file. The administrator was questioned regarding Caregiver #4. She confirmed that the caregiver had worked at a different facility owned by the same company, and that there were problems with her. She said they were moving her around, trying to find a place for her. Refer to 7.8.2.34(D)(5) Based on record review and interview, the facility failed to provide humane care by failing to administer pain medication to Resident #1 while she was "screaming out in pain." The findings are: A. On 10/10/06 at 2:00 p.m., during record review of Resident #1's chart, the following was revealed: 1. A facility daily log dated 9/21/06 read: 11-7 ...her back is hurting. Screaming in pain. 2. The daily log dated 9/22/06 read: 11-7 ... [resident] is not having a good morning.	A34 D)	Caregiver #4 was transferred from Bee Hive I because of personal issue and she was transfered to give her a fresh start on a new environment with new caregivers and co workers.	

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A34	Continued From page 53 Screaming because of her back. B. On 10/10/06 at 2:00 p.m., review of the September 2006 Medication Administration Record (MAR) revealed a prescription for "Hydrocodone/APAP 5/500 tab, take 1 tablet by mouth every morning." Further review of the MAR showed Hydrocodone was given at 5:30 a.m. on 9/21/06 but not administered to the resident at all on 9/22/06. Review of the back of the MAR read 9/22/06 Hydrocodone, Reorder Dr. Authorize, Waiting for delivery. Resident #1 was not administered any pain medication on 9/22/06. C. On 10/10/06 at 3:00 p.m., during an interview the Manager stated, "On 9/21/06 and 9/22/06 she [Resident #1] did not get anything for pain. The MAR says Hydrocodone was on reorder. She had Tylenol, no wait, she didn't get Tylenol she got Aleve." When the surveyor was reviewing the MAR with the Manager, for 9/21/06 and 9/22/06, the MAR showed no documentation that Aleve was given for pain or that is had been ordered. The Manager then confirmed by stating, "No, she didn't get anything for pain." D. On 10/11/06 at 2:45 p.m., review of the resident's chart revealed a Physician's order dated 9/3/06 prescribing "Vicodin (Hydrocodone/Acetaminophen) 5/500 take 1 or 2 by mouth every 4-6 hrs for pain."	A34	B) Resident 1 was offered tynael $ adwil she refused documentation of that was in the documentation book which was given to the Inspector upon Inspection. C) the manager was going by the MAR not the documentation book, It was documented there. D) we had calls out to the docters to get prescription Refilled.	
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.	A36	In the furture the facility will work more Efficiently and effectively collaborate with the	

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A36	Continued From page 54 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 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	A36	Resident, their family and their doctors to ensure that everyone is on the same page and appropriate documentation is completed with regard to the resident medication and. Staff will be Retrained accordingly.	

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A36	Continued From page 55 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: (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 NMAC 8.2.36(C)	A36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING _____ B. WING _____	C 10/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE RIO RANCHO, NM 87124

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A36	Continued From page 56 Based on record review and interview, the facility failed to ensure prescribed medications for 1 of 11 residents (#6) were not discontinued by the facility without an order from the physician. The findings are: A. On 10/13/06 at 7:54 a.m., review of Resident #6's record revealed that this resident was admitted to the facility on 8/17/06 with a diagnosis of alcohol induced dementia. Further review of the record showed a past medical history of ETOH (alcohol) dependence, PTSD and a history of borderline traits, and severe cognitive impairments. B. On 10/13/06 at 7:54 a.m., review of the resident's September 2006 Medication Administration Record (MAR) revealed that the resident had not been receiving his prescribed medication of Zoloft 100mg since September 20, 2006. The order on the MAR reads: Zoloft 100mg take 1 tab by mouth daily. Further review of the chart revealed no MAR for the month of October 2006. 1. Resident #6 had also not been receiving his prescribed medication of Namenda 10mg since September 22, 2006. The order on the MAR read: Namenda 10mg take 2 tabs Q day. 2. Resident #6 had not been receiving his prescribed medication of Folic Acid 1mg since September 21, 2006. The order on the MAR read: 1 tablet by mouth daily. 3. Resident #6 had not been receiving Vitamin B1 100mg since September 24, 2006. The order on the MAR read: Vitamin B1 100mg take 3 tabs by mouth 3 times day 4. Resident #6 had not been receiving Multivitamin/Iron since September 21, 2006. The order on the MAR read: Multivitamin/Iron take 1	A36 1A)	Resident #6 POA Signed a letter Stating she dosenot want Resident # 6 to have meds if she dose not want them. Resident # 6 also Signed a Statement. Staff had left numerous messages to # 6 docter to inform him of #6 action. Resident then kept Refusing medication and no unexspeable behavior has accured with him not taken his meds. Staff called	

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A36	Continued From page 57 tab a day. C. On 10/13/06 at 8:10 a.m., during an interview, the Assistant Manager stated, "Yes he [Resident #6] has been without his meds for sometime now. We notified family and the family wanted to try to see how he would do without the meds." She said that the father of the resident stated that the family wanted to wait one more week to see how he did. If he did okay, then they were not going to worry about the medications. The Assistant Manager further stated the resident "Had been doing fine without the medications. But, you would expect to see someone though whose on a antidepressant to have some reaction if they're not getting it." D. On 10/13/06 at 8:45 a.m., during an interview the Manager stated that "There was never a physicians order to d/c (discontinue) his meds. The doctor I notified, told me that the family had to go back to the original doctor who prescribed them." The Manager further stated that the "Doctor authorization never came." E. On 10/13/06 at 8:50 a.m., during an interview, regarding his medications, Resident #6 stated, "If they bring them, yeah I'll take them. I think they've been without them for a while now. If my dad brings them then I'll take them but I know I haven't taken them for a while." F. On 10/13/06 at 1:35 p.m., during an interview the Administrator stated, "There is no physicians order." G. On 10/13/06 at 4:20 p.m., during an interview with a family member of Resident #6, it was stated, "Yes there were two meds he was taking and we felt they were no longer needed. We	A36	doctor and informed him of his actions.	

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A36	Continued From page 58 thought they made him worse off. I decided to drop them to see how he reacts without them. If he felt better, then I would go ahead and leave him off of them." H. On 10/20/06 at 5:00 p.m., review of a Nursing 2005 Drug Handbook revealed the following: Zoloft (Sertraline Hydrochloride) Patient Teaching: Instruct patient to avoid stopping the medication abruptly I. On 10/20/06 at 5:10 p.m., review of Davis's Drug Guide for Nurses Sixth Edition read as follows: 1. Zoloft: Nursing Implications Assessment: Depression, Monitor mood changes. Inform physician or other health care professional if patient demonstrates significant increase in anxiety, nervousness, or insomnia. 2. Patient/Family teaching: Instruct patient to take exactly as directed. If a dose is missed, take as soon as possible and return to regular dosing schedule.	A36		