

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2008
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF FARMINGTON #2		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH LOCKE FARMINGTON, NM 87401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A35	7 NMAC 8.2.35 Custodial Drug Permit 7.8.2.35 CUSTODIAL DRUG PERMIT: Any facility licensed pursuant to these regulations who supervises the administration, self-administration, or safeguards medications for residents, must have a current custodial drug permit issued by the State Board of Pharmacy. EXCEPTION: Adult residential care facilities with one (1) resident are not required to have a custodial drug permit. A. PROCUREMENT, LABELING, AND STORAGE: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as required by the individual or specified by the individual's health care plan. The facility shall procure, label, and store medications for residents in a manner which shall be in compliance with state and federal laws. (1) All medications, including non-prescription drugs, will be stored in a locked compartment or in a locked room, as approved by the Board of Pharmacy, and the key will be in the care of the director or designee. (2) Internal medication must be kept separate from external medications. Drugs to be taken by mouth will be separated from all other dosage forms. (3) A separate locked compartment will be available in the refrigerator for those items labeled "keep in refrigerator." The refrigerator temperature will be kept between thirty-five (35) and forty-five (45) degrees Fahrenheit. A thermometer is required to be kept in the refrigerator. (4) All medications, including non-prescription medications, must be stored in separate compartments for each resident and all medications will be labeled with the residents' names.	A35		

Division of Health Improvement
Retha L. Jackson
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator (X6) DATE

9/10/08

STATE FORM

RECEIVED

W75W11

If continuation sheet 1 of 8

SEP 2008

HEALTH FACILITY LICENSING

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/26/2008
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF FARMINGTON #2			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH LOCKE FARMINGTON, NM 87401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A35	Continued From page 1 (5) A resident may be permitted to keep his/her own medication in a secure place in his/her room for self-administration if the physician's report has deemed it appropriate that the resident do so. (6) The facility may not require the resident to purchase prescriptions from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes must comply with National Fire Protection Association (NFPA) 99. B. CONSULTING PHARMACIST: The facility shall maintain records demonstrating the consulting pharmacist provides the following: (1) Reviews the medication regimen as needed, but at least quarterly (every three (3) months), to determine that all medications and records are accurate and current. All irregularities must be reported to the Director of the facility and these irregularities must be acted upon. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation is provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. [7-1-64, 9-15-70, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.35 NMAC - Rn, 7 NMAC 8.2.35, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.35 (B) - Consultant Pharmacist	A35			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/26/2008
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF FARMINGTON #2			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH LOCKE FARMINGTON, NM 87401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A35	Continued From page 2 Based on record review and interview, the facility failed to ensure that the irregularities indicated by the pharmacist were acted upon for 2 residents. The findings are: A. On 8/26/08 during review of the pharmacy reports for 2/08 and 5/08. These reports indicate perpetual count problems for 1 resident taking Oxycodone and Xanax and another taking Xanax spanning a time of three months. No records were available to indicate resolution of the issue. B. On 8/26/08 at 10:30 AM during interview with the on site manager, she acknowledged the problem.	A35	A35 9-9-08 (12.3.1) Review of documents show a documentation failure. Medications were not signed off when given. All dosing was tracked & errors corrected. (12.3.2) Consultation w manager on proper documentation. Mandatory shift counts will be enforced at beginning + end of each shift. Shift (12.3.3) leaders will assist with medication + will be responsible for documentation checks for each shift. Oncoming shift leader & outgoing shift leader will count & sign off on all counts. Immediate notification of Nurse - Administrator - + House Manager - Review of records & consult with shift leaders about any discrepancies. (12.3.4) 9-10-08 monitoring plan in place. Nurse Audits being done upon notice of problems.		
A36	7 NMAC 8.2.36 Medications 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws. A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. C. No medications, including over the	A36			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/26/2008
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF FARMINGTON #2			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH LOCKE FARMINGTON, NM 87401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A36	Continued From page 3 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 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.	A36			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2008
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF FARMINGTON #2		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH LOCKE FARMINGTON, NM 87401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A36	Continued From page 4 (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 7.8.2.36(C) - Physician's Orders Based on observation, record review and interview, the facility failed to ensure that medications were given in accordance with accurate and current physician orders for 100% of residents. The findings are: A. On 8/26/08 during review of the resident's physical medications and review of written physician orders, it was noted that the records did not match the physical medication containers for residents.	A36	A-36 (12.3.1) Pharmaceutical Training + Consultation Review of labels + MAR (12.3.2) Physicians contacted for correct orders + updated	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2008
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF FARMINGTON #2		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH LOCKE FARMINGTON, NM 87401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A36	Continued From page 5 B. On 8/26/08 at 10:30 AM during interview with the on site manager, she confirmed that the orders for all residents needed to be updated for accuracy with the physical medications being taken.	A36	(12.3.3) Nurse Audits - Shift Counts - House manager trained on Audit process 12.3.4 9/9/08 All procedures in place + active	
A59	7 NMAC 8.2.59 Fire Clearance & Inspections 7.8.2.59 FIRE CLEARANCE AND INSPECTIONS: A. Written documentation from the State Fire Marshall's office or Fire Prevention Authority having jurisdiction indicating a facility's compliance with applicable fire prevention codes shall be submitted to the Licensing Authority prior to issuance of a initial license. B. Each facility shall request from the local fire prevention authorities an annual fire inspection. If the policy of the local fire department does not provide for annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7-1-64, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.59 NMAC - Rn, 7 NMAC 8.2.59, 8-31-00] This REQUIREMENT is not met as evidenced by: Refers to 7.8.2.59.B - Fire Marshall Inspection Based on record review and interview, the facility failed to keep documentation of annual fire inspection report. The findings are:	A59	A59 (12.3.1) Fire Marshall contacted 9/29/08 Safety of all residents (12.3.2) affected if not current on this 12.3.2 (12.3.3) Review files monthly for up to date inspections (12.3.4) Inspection scheduled with Fire Department 3PM. Monday 9/15/08 Quarterly Biannual inspections are done by Farmington Fire Equipment. Cy Cooper Company Inspects Sprinkler systems biannually.	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2008
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF FARMINGTON #2		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH LOCKE FARMINGTON, NM 87401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A59	Continued From page 6 A. During review of administrative paperwork, the last fire inspection report posted was over 12 months ago. B. On 8/26/08 at 10:30 AM during interview with the on site manager, she confirmed that she did not have a current fire inspection report.	A59		
A66	7 NMAC 8.2.66 Related Regulations & Codes 7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96). B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96). C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to NMAC 7.1.12.8(a) Employee Abuse Registry (Effective January 1, 2006) - Care Provider requirement to inquire of registry prior to offer of employment to applicants. Based on record review and interview, the facility failed to maintain documentation that the Employee Abuse Registry (EAR) database was checked prior to offer of employment 100% of newly hired staff. The findings are:	A66	A 66	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/26/2008
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF FARMINGTON #2			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH LOCKE FARMINGTON, NM 87401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A66	Continued From page 7 A. On 8/26/08 at 10:30AM during review of the employee files, it was noted that newly employed staff did not have documentation of search on the EAR database using the individual's identifying information. B. On 8/26/08 at 10:30 AM, during interview with the on-site manager, she acknowledged that the information was not available for review.	A66	A66. 12.3.1 Manager reprimanded on failure to COR. 1 worker 12.3.2 Failure puts all residents at risk 12.3.3 Review records monthly for compliance 12.3.4 08/26/2008 House manager CORed new employee.		