

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2025
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF ALBUQUERQUE - WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 6000 WHITEMAN DRIVE NW ALBUQUERQUE, NM 87120		
(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
8 000	Initial Comments The following deficiency was cited during a Complaint survey completed on 01/08/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living for Adults. Resident Census: 14 Complaint intake NM [REDACTED] was investigated and deficiencies were not cited.	8 000		
8 032	8 NMAC 370.14.32 Reporting of Incidents A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 NMAC. (1) The facility shall 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 complaint hotline within 24 hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 8.370.9 NMAC; and	8 032		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Gould S. Hamilton

TITLE

Owner

(X6) DATE

02/09/25

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8 032	Continued From page 1 (3) plans for further actions in response to the incident. [8.370.14.32 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.32 A (1) and B REPORTING OF INCIDENTS: A. The facility shall ensure (to make certain that something shall occur or be the case) that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 NMAC. (1) The facility shall 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 complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the bureau incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. Based on record review and interview, the facility	8 032			

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8 032	Continued From page 2 failed to ensure for 1 (R #1) of 1 resident whose incident reports were reviewed for compliance that: 1. Incident reports were reported to the Licensing Authority within twenty-four (24) hours and an internal investigation was not conducted and submitted to the Licensing Authority (LA) within five (5) business days from when an incident occurred. These deficient practices could likely result in the resident to be at risk of harm, injury, or death if incidents with injury are not reported to the Licensing Authority. The findings are: A. Record review of the facility's internal incident report dated 01/23/24, R #1 had a fall with bruising and was sent to the hospital with [REDACTED]. B. On 01/08/25 at 1:30 pm, during an interview, the House Manager confirmed R#1's fall on 01/23/24 not reported to the Licensing Authority within 24 hours and an internal investigation was not conducted and submit to the Licensing Authority within five business days from when an incident occurred.	8 032	The facility administrator will report incidents and unusual occurrences per 8.370.9 NMAC within 24 hours or the next business day. The administrator will investigate the incident and file a follow-up report with the Health Care Authority within 5 business days, listing any corrective action taken. The administrator will review all incidents weekly to ensure that incidents and unusual occurrences are reported and investigated timely as required.	01/30/25