STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
BEE HIVE HOMES OF RIO RANCHO II	2709 CHESSMAN DRIVE NE RIO RANCHO, NM 87124	1/5/2023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Full-Onsite/Complaint survey completed on 08/25/22 for the state requirements of NMAC 7.8.2 , Regulations for Assisted Living Facilities for Adults. Complaint Intake NM# 58341 was unsubstantiated without deficiencies cited. Complaint Intake NM# 56963 was unsubstantiated without deficiencies cited. Complaint Intake NM# 57837 was unsubstantiated with deficiencies cited. Complaint Intake NM# 57891 was unsubstantiated without deficiencies cited	A 000		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident	A 017		

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A 017	Continued From page 1 information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A. B. Based on record review and interview the facility failed to ensure that that the Direct Care Staff (DCS) received sixteen (16) hours of supervised training prior to providing unsupervised care and there was documentation of completion in their personnel files . This deficient practice could likely result in the 14 (R #s 1-14) residents listed on the resident census, provided by the House Manager on 08/03/22, to be at risk of harm if they are receiving care and services by DCS who have not received the required trainings. The findings are:	A 017	A 017 DCS#2-6 Employee's sixteen (16) hours of supervised training will be completed and filed prior to providing unsupervised care. The House Manager will ensure ongoing compliance and documentation for new hires to receive 16 hours of supervised training prior to unsupervised care .	11/15/2022

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A 017	Continued From page 2 A. Record review of DCS #2's (hire date 02/25/22) training files, revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents. B. Record review of DCS #3's (hire date 07/07/21) training files, revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents. C. Record review of DCS #4's (hire date 06/10/22) training files, revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents. D. Record review of DCS #5's (hire date 08/04/21) training files, revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents. E. Record review of DCS #6's (11/16/08) training files, revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents. F. On 08/12/22 at 11:30 am, during an interview with the House Manager, she confirmed that DCS #'s 2-6, did not complete the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents.	A 017		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an	A 025		

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A 025	Continued From page 3	A 025		

appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility.
B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status.
C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status:
(1) activities of daily living;
(2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc;
(3) communication and hearing; ability to communicate needs and understand instructions, etc;
(4) vision;
(5) physical functioning and skeletal problems;
(6) incontinence of bowel/bladder;
(7) psychosocial well-being;
(8) mood and behavior;
(9) activity interests;
(10) diagnoses;
(11) health conditions;
(12) nutritional status;
(13) oral or dental status;
(14) skin conditions;
(15) medication use and level of assistance needed with medications;
(16) special treatments and procedures or special medical needs such as hospice; and
(17) safety needs/high risk behaviors; history of

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A 025	Continued From page 4 falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 E. Based on record review and interview the facility failed to ensure for 3 (R #s 3-5) of 6 (R #s 1-6) residents whose evaluations were reviewed for compliance that they were reviewed and if needed revised by an LPN (Licensed Practical Nurse), RN (Registered Nurse, or a PE (Physician Extender) as required by regulation. This deficient practice could likely result in the residents not receiving the appropriate care and assistance, if their evaluations have not been reviewed and updated by an LPN, RN, or PE. The findings are: A. Record review of R #3's resident evaluation	A 025	A025 Resident evaluations will be reviewed and if needed, revised by the house manager.The Facility house registered nurse will then review and if needed revise the evaluation. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occur.	11/21/2022

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A 025	Continued From page 5 dated 07/25/22, revealed no documentary evidence that it was reviewed by a LPN, RN or PE. B. Record review of R #4's resident evaluation dated 04/07/22, revealed no documentary evidence that it was reviewed by a LPN, RN, or a PE. C. Record review of R #5's resident evaluation dated 07/03/22, revealed no documentary evidence that it was reviewed by a LPN, RN, or a PE. D. On 08/03/22 at 3:50 pm, during an interview with the House Manager, she confirmed that the evaluations for R #s 3-5 were not reviewed and updated by a LPN, RN, or a PE.	A 025		
A 032	7 NMAC 8.2.32 Reporting of Incidents 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 7.1.13 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. (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 (5) business days and shall submit a copy of the investigation report to the licensing	A 032		

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A 032	Continued From page 6 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 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) (2) B (1-3) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13. & A. (1) (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor ' s order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form	A 032	A032 The house manager will ensure that all incident reports are complete and compliant and follow all regulation directives and reportable incidents will be reported within 24 hrs . The house manager will ensure to Conduct internal investigations for incidents and/or submit an Investigation Follow-up report to the Licensing Authority within 5-business days from the date the incident occurred.	11/15/2022

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consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form.

Based on record review and interview the facility failed to ensure for 2 (R #s 2 & 6) of 6 (R #s 1-6) residents whose Internal Incident Reports were reviewed for compliance that incidents of physical abuse and unwitnessed falls with injury:
1. Were reported to the Licensing Authority within 24-hours, or the next business day if a holiday or weekend.
2. That investigations were conducted by the facility, and investigation follow-up reports were submitted to the Licensing Authority within 5 business days from the dates the incidents occurred.

This deficient practice could likely result in the residents to be at risk of harm, injury, or death if, there is no oversite by the Licensing Authority

The findings related to R #2

A. Record review of R #2's Internal Incident Report dated 09/28/21, revealed that on 09/28/22 at 2:20 pm when the Direct Care Staff (DCS)

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went to change R #2 [redacted] started yelling, scratching, flailed (swinging or waving) [redacted] arms, and kicking at the DCS, which resulted in:
1. R #2 having a [redacted] (report does not state how/why injuries occurred).
2. DCS # 5 sustained scratches to [redacted]
3. Hospice was notified and a nurse was coming out to check on resident's skin tears.
4. There was no documentation that the incident was reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend.
5. There was no documentation that the facility conducted an investigation and/or that that a follow-up investigation report was submitted to the Licensing Authority within 5-business days after the date of the incident.

The findings related to R #6

B. Record review of R #6's, Internal Incident Report dated 04/18/22, revealed that on 04/18/22 at 9:44 pm, the resident had an unwitnessed fall and complained of pain of [redacted] There was no documentation that Emergency Services were called or if R #6 received medical treatment. There was no documentation that the:
1. Incident was reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend.
2. Facility conducted an investigation and/or that that a follow-up investigation report was submitted to the Licensing Authority within 5-business days after the date of the incident.

C. On 08/10/22 at 1:05 pm, during an interview with the Administrator, she confirmed that the facility failed to:

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A 032	Continued From page 9 1. Report the above listed incidents for R #s 2 & 6 to the Licensing Authority within 24 hours or the next business day if a holiday or weekend. 2. Conduct internal investigations for the above listed incidents for R #s 2 & 6 and/or submit Investigation Follow-up reports to the Licensing Authority within 5-business days from the date the incident occurred.	A 032		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. 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 from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing.	A 035		

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A 035	Continued From page 10 C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the	A 035		

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prescriber of the medication;
(4) the diagnosis or reason for the medication;
(5) the name of the medication, including the drug product brand name and the generic name;
(6) notation if the medication is a schedule II-IV drug;
(7) the dosage of the medication;
(8) the strength of the medication;
(9) the frequency or how often the medication is to be taken or given;
(10) the route of delivery for the medication (mouth, eye, ear, other);
(11) the method of delivery for the medication (pills, drops, IM injection, other);
(12) the date that the medication was started or discontinued;
(13) any change in the medication order;
(14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order;
(15) the date and time that the medication is self-administered, administered with assistance or is administered;
(16) the initials and signature of the person assisting with or administering the medication;
(17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.);
(18) any refused dose of medication;
(19) any missed dose of medication; and
(20) any medication error.
H. No medication shall be stopped or started without specific orders from the primary care physician.
I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.
J. A suspected adverse reaction to a medication shall be documented on the MAR and reported

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A 035	Continued From page 12 immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (5) Based on record review, observation, and interview the facility failed to ensure for 5 (R #s 1, 3, 4, 5 and 6) of 5 (R #s 1, 3, 4, 5, and 6)	A 035	A035 The House manager will ensure that all resident MARS will include both the generic and brand names of all resident medications.	11/30 2022

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

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A 035	Continued From page 13	A 035		

residents whose Medication Administration Records (MARs) were reviewed for compliance, included both the generic and brand names of the medications.

This deficient practice could likely result in the residents being at risk of harm, illness, or death if medication errors occurred because the Direct Care Staff (DCS) are not familiar with the names of the medications, if both the brand and generic names are not listed on the MARs, and residents are given the wrong medications. The findings are:

A. Record Review of R #1's MARs dated 07/01/22 through 08/05/22, revealed that the following medications did not include both the brand/generic names:

B. Record Review of R #3's MAR dated 07/01/22 through 08/05/22 revealed that the following medications did not include both the brand/generic names:

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A 035	Continued From page 14	A 035		

[redacted]

C. Record Review of R #4's MAR dated 07/01/22 through 08/05/22 revealed that the following medications did not include both the brand/generic names:

[redacted]

D. Record Review of R #5's MAR dated 07/01/22 through 08/05/22 revealed that the following medications did not include both the brand/generic names:

[redacted]

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A 035	Continued From page 15 [redacted] E. Record Review of R #6's MAR dated 07/01/22 through 08/05/22 revealed that the following medications did not include both the brand/generic names: [redacted] F. On 08/25/22 at 9:26 am, during the exit interview, the Administrator and Manager confirmed that R #s 1, 3, 4, 5 and 6 MARs did not include both the brand/generic names of the medications listed above.	A 035		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and	A 037		

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A 037	Continued From page 16 layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (10) Based on observation and interview the facility failed to ensure that the laundry/cleaning supplies	A 037		

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A 037	Continued From page 17 were kept in a secured room, closet, or cabinet. This deficient practice could likely result in the 14 (R #s 1-14) residents identified on the census provided by the House Manager on 08/03/22, to be at risk of harm or injury if they were to ingest or spill laundry or cleaning supplies on their face or body. The findings are: A. On 08/03/22 at 9:37 am, during observation of the unlocked facility laundry room, the following laundry and cleaning supplies were observed to be unsecured and accessible to residents: 1. (1) one, 1 quart bottle of liquid heavy duty degreaser. 2. (1) one, 50 pound box of powdered laundry detergent. 3. (1) one, 12.5 ounce aerosol can wood protector cleaner 4. (1) one, 24 ounce bleach toilet bowl cleaner 5. (1) one, 20 ounce heavy starch B. On 08/12/22 at 12:00 pm, during an interview with the House Manager, she confirmed that the above listed laundry and cleaning supplies were stored in the unlocked laundry room, unsecured, and accessible to residents.	A 037	A037 The house manager will ensure that the laundry/cleaning supplies will be kept in a secured room/closet/or cabinet .	11/30 2022
A 045	7 NMAC 8.2.45 Water WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC. A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations. B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non-community water system as defined by the current New	A 045		

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A 045	Continued From page 18 Mexico drinking water requirements. C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented from entering potable water systems by appropriate cross connection and backflow prevention devices. D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries. E. The hot water temperature that is accessible to residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury. [7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.45 (E) Based on observation and interview, the facility failed to ensure the bathroom hot water temperatures were maintained at a maximum of 110 degrees Fahrenheit (F). This deficient could likely result in the 14 (R #s 1-14) residents listed on the census list provided by House Manager on 08/03/22, to be at risk of being burned by water that is too hot. The findings are:	A 045	A045 The house manager will ensure that the The hot water temperature that is accessible to residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised . We did Turn down the Water heater so that the temperature meets the temp requirements.	11/30/ 2022

J Figueroa 1/5/2023

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A 045	Continued From page 19 A. On 08/09/22 at 1:19 pm, during an observation of room #11, the hot water temperature was found to be at 118-degrees Fahrenheit. B. On 08/26/22 at 9:45 am, during an interview with the House Manager and Administrative Assistant, they confirmed that the hot water temperature in room #11 was 118-degrees Fahrenheit.	A 045		
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC,	A 047		

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A 047	Continued From page 20 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.47 E Based on observation and interview the facility failed to ensure that all emergency lights in the facility were in working order. This deficient practice could likely result in the 14 (R #s 1-14) residents identified on the census provided by the House Manager on 08/03/22, to be at risk of harm, injury, or death, if there is a power outage or other emergency requiring evacuation occurs and the residents cannot see to safely exit the building. The findings are: A. On 08/03/22 at 9:33 am, during observation and testing of the facilities emergency lights, the emergency light by room number #4 failed to light up when tested. B. On 08/03/22 at 9:42 am, during observation and testing of the facilities emergency lights, the emergency light by the back door exit to the patio failed to light up when tested. C. On 08/03/22 at 2:35 pm, during an interview with the House Manager, she confirmed that the facilities emergency lights located in the locations stated above are not in working order.	A 047	A047 The Manager will ensure that all emergency lights will be in working order . The emergency lights were replaced as of 11/30/2022	11/30 2022
A 049	7 NMAC 8.2.49 Doors DOORS:	A 049		

J Figueroa 1/5/2023

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A 049	Continued From page 21 A. No door in any means of egress shall be locked against egress when the building is occupied. (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities. E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside.	A 049		

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A 049	Continued From page 22 F. All doors shall readily open from the inside. G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms. [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.49 F Based on observation and interview, the facility failed to ensure that the resident bedroom doors could be readily opened from the inside when locked. The deficient practice could likely result in the 14 (R #s 1-14) residents listed on the resident census, provided by the Manager on 08/03/22, to be at risk of injury, harm, or death if their bedroom doors are locked and they are unable to evacuate in the event of a fire, loss of power, or other emergency that requires evacuation occurs. The findings are: A. On 08/12/22 at 12:47 pm, during observation of resident bedroom #s 1-15. the doors were observed to have a lock that would not readily open to exit the bedroom. B. On 08/12/22 at 3:30 pm, during an interview with the House Manager, she confirmed the observation that the doors in all resident bedrooms would not readily open to exit.	A 049	A 049 The manager will ensure that the resident bedroom doors will readily be able to be opened from the inside when locked. We replaced all doors with new door handles to meet the regulations .	11/30 2022
A 059	7 NMAC 8.2.59 Windows WINDOWS: A. Each sleeping room shall be provided with an exterior window. (1) The window shall be operable, screened and	A 059		

J Figueroa 1/5/2023

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A 059	Continued From page 23 have a clear operable area of 5.7 square feet minimum; measured twenty (20) inches wide minimum and measured twenty-four (24) inches high minimum. (2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor. B. Screens shall be provided on all operable windows. C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.59 B Based on observation and interview the facility failed to ensure that all of the facility's windows had screens. This deficient practice could likely result in the 14 (R #s 1-14) residents identified on the census provided by the House Manager on 08/03/22, to be at risk of injury or illness if they are exposed to bugs/insects, allergens, or debris coming in through the windows with improperly fitted screens. The findings are: A. On 08/03/22 at 9:51 am, during observation of the exterior of the facility, it was observed that the	A 059	A 059 The manager will ensure that all of the facility windows have screens . Our findings were that the living room window has a screen with no damage and had a 1/4 inch gap .	11/09 2022

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A 059	Continued From page 24 facility's living room window did not have a properly fitted screens and had damage B. On 08/03/22 at 3:50 pm, during an interview with the House Manager, she confirmed that the facility's living room window screen was damaged and not properly fitted.	A 059		
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.62 National Fire Protection Agency (NFPA) 13.6.2.7.1 Plates, escutcheons, or other devices used to cover annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. Based on observation and interview, the facility failed to ensure the automatic fire sprinkler system had the sprinkler heads plate covers (escutcheons) maintained throughout the facility. This deficient practice could likely result in the 14 (R #s 1-14) residents listed on the census	A 062	A 062 The house manager will ensure the automatic fire sprinkler system has the sprinkler heads plate covers (escutcheons) maintained throughout the facility. We contacted the Sprinkler system company to come and and fix the plate covers	11/30 2022

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

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A 062	Continued From page 25 provided by the Administrator on 08/03/22, to be at risk of harm, injury or death, if the sprinkler system did not function properly if a fire were to occur. The findings are A. On 08/09/22 at 11:08 am, during an observation of the facility, the following escutcheons (plate covers) around the sprinkler heads were observed to be missing and created drywall penetrations (holes) in the ceiling: 1. One (1) of the sprinkler heads missing the escutcheon in room number 11. 2. One (1) plate cover missing in the heater room B. On 08/09/22 at 11:09 am during an observation of the facility, the following escutcheons were observed depressed and not flush to the ceiling: 1. One (1) escutcheon near the west side of the dining room of the facility 2. One (1) escutcheon in R #12 3. One (1) plate cover across from room #14 4. One (1) outside of room 11 in the hallway 5. One (1) escutcheons had drywall penetration surrounding it in room 11. 6. One (1) escutcheon in the hallway, outside rooms 8 and 9 C. On 08/09/22 at 11:30 am, during an interview with the Administrator, she confirmed that the escutcheons were missing from the sprinkler heads in room 11, 12 and others sprinkles through out the facility, in the hallways including the heater room, and dining room down the the west hall.	A 062		
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training	A 066		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	C 08/25/2022

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A 066	Continued From page 26 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month. (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes. (5) The local fire department may be requested to	A 066		

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A 066	Continued From page 27 supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.66 A B C D (3-4) Based on record request, record review, and interview the facility failed to ensure that the: 1. Direct Care Staff (DCS) were trained on the procedures to detect and eliminate potential safety hazards, properly use fire extinguishers, evacuation techniques and the other procedures in case of fire or other emergencies. 2. Residents were informed of the location of the facility fire exits, fire extinguishers, and instructed in the actions to take in case of a fire or other emergency. 3. Monthly fire drills were conducted in the facility that place emphasis on orderly evacuation of the facility. These deficient practices could likely result in the 14 (#s 1-14) residents listed on the census, provided by the House Manager on 08/03/22, to be at risk of harm, injury, or death if a fire or other emergency that required evacuation were to occur, if the: 1. DCS do not know the procedures to follow in order to eliminate safety hazards, how to use a fire extinguishers, or how to orderly evacuate residents from the facility. 2. Residents have not received evacuation training, and do not know how to safely evacuate the facility. 3. DCS are not aware of resident issues that occur during the evacuation or the time it takes	A 066	A 066 The manager will ensure that all fire drills will Include all residents in the monthly Fire Drills. Document any problems related to residents evacuating the facility. Document the total time in minutes for residents to evacuate the facility. Residents and family of residents are given the initial tour and are shown the exits and inside our Admission packets we do go over Fire drills and Fire safety and signed by Resident and/or POA	11/30 2022

1/5/2023

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A 066	Continued From page 28	A 066		

for the staff to safely evacuate the residents from the facility.

The findings are:

A. Record request for DCS #s 1-6 safety training records, revealed no documentation that the DCS completed Fire Safety training that included:
1. The procedures to detect and eliminate potential safety hazards.
2. Proper use a fire extinguishers.
3. Evacuation techniques.

B. Record review of R #s 1-6 resident records, revealed no documentation that the resident/families fire safety orientation that included:
1. The location and use of fire extinguishers.
2. Location of fire exits.
3. Instruction on the actions to take in case of a fire or other emergency.

C. Record request of the facility Fire Evacuation Drill Evaluation Checklists, revealed that the facility:
1. Failed to conducted and document monthly fire drills.
2. Fire Evacuation Drill Evaluation Checklists, revealed that the facility did not:
a. Place emphasis on orderly evacuation (of residents) from the facility.
b. Have residents participate in the evacuation of the facility during fire drills.

D. On 08/10/22 at 12:07 pm, during an interview with the Administrator, she confirmed that there was no documentation onsite and available for review for the following:
1. Fire Safety training records for DCS #s 1-6 including:

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A 066	Continued From page 29 a. Completing fire drill training. b. Completing training that included the procedures to detect and eliminate potential safety hazards, c. Being trained on the proper use fire extinguishers. d. Being trained on evacuation techniques. 2. Documentation of R #s 1-6, receiving orientation training that included: a. How to evacuate to the nearest emergency exit. b. The location and use of fire extinguishers. c. The location of telephones that can be used in an emergency. d. Being instructed in the actions to be taken in case of fire or other emergencies. e. Evacuation time in minutes for residents evacuating to the emergency exits during fire drills. E. On 08/10/22 at 12:07 pm, during an interview with the Administrator, she confirmed that the facility did not: 1. Include residents in the monthly Fire Drills. 2. Document any problems related to residents evacuating the facility. 3. Document the total time in minutes for residents to evacuate the facility because residents are not participating in the fire drills.	A 066		