STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2106	A. BUILDING: _____ B. WING _____	R-C 05/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENT FY NG INFORMATION)	ID 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 Follow-Up/Revisit survey completed on 05/23/23 for the state requirements of NMAC 7.8.2 , Regulations for Assisted Living Facilities for Adults. Census: 11 DEFINITIONS cap: capsule DC'd: discontinued DCS: direct care staff DR: delayed release ER: extended release ES: extra strength g: gram HCl: hydrochloride LPN: licensed practical nurse MAR: medication administration record mg: milligram ml: milliliter PE: physician extender R: resident Rm: room RN: registered nurse tab: tablet XL: extended release	{A 000}		
{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	{A 032}		

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{A 032}	Continued From page 1 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 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: This is an uncorrected deficiency from survey dated 08/25/22, 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)	{A 032}		

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{A 032}	Continued From page 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 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 7 & 8) of 4 (R #s 1, 2, 7 & 8) residents whose Internal Incident Reports were reviewed for compliance; that any incident or unusual occurrence which has or could threaten the health, safety or welfare of the residents: 1. Were reported to the Licensing Authority within 24-hours, or the next business day if a holiday or weekend.	{A 032}		

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{A 032}	Continued From page 3 2. That internal investigations were conducted by the facility, and investigation follow-up reports were submitted to the Licensing Authority within five (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, and/or death, if incidents of possible abuse, neglect, exploitation, or unusual occurrence occur and there is no oversight by the Licensing Authority. The findings are: Findings related to R #7: A. Record review of R #7's Internal Incident Report dated 04/23/23 at 11:30 am, revealed: 1. The resident was sitting in a wheelchair, leaned forward and fell out, and hit [redacted] on the floor with no indication of whether the fall was witnessed or unwitnessed. 2. The DCS called an ambulance and R #7 was transported to the hospital. 3. There was no documentation that the incident was reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend. 4. There was no documentation that the facility conducted an investigation and/or that a follow-up investigation report was submitted to the Licensing Authority within five (5) business days after the date of the incident. B. On 05/22/23 at 10:25 am, during an interview with the Administrator, he stated that the DCS don't normally make progress notes and that he was unable to provide progress notes for R #7 for the 04/23/23 incident.	{A 032}		

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{A 032}	Continued From page 4 Findings for R #8: C. Record review of R #8's Internal Incident Report dated 04/10/23, revealed that on 04/10/23 at 12:30 pm, the resident: 1. Had an unwitnessed fall on the bathroom floor. The resident stated that she was going to the bathroom with [redacted] heard [redacted] phone ring and [redacted] got frightened and fell. 2. The incident report did not indicate whether or not there was injury, but the paramedics were called, and after the examination, the report states that the staff needs to keep a close eye on [redacted] 3. 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. 4. 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 five (5) business days after the date of the incident. D. On 05/22/23 at 10:25 am, during an interview with the Administrator, he confirmed that the facility failed to: 1. Report the above-listed incidents for R #s 7 & 8 to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend. 2. Conduct internal investigations for the above listed incidents for R #s 7 & 8 and/or submit investigative follow-up reports to the Licensing Authority within five (5) business days from the date the incident occurred.	{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. Training will be given using DHI power point to all responding staff.	06/30/2023
A 034	7 NMAC 8.2.34 Custodial Drug Permits	A 034		

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A 034	Continued From page 5 CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular	A 034		

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A 034	Continued From page 6 pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (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 shall be	A 034		

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A 034	Continued From page 7 reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be 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. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7) Refer to: NFPA (National Fire Prevention Association) 99. 2012 Edition. 11.3 Cylinder and Container Storage Requirements. 11.3.1 * Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2 * Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible	A 034		

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A 034	Continued From page 8	A 034		

construction, with doors (or gates outdoors) that can be secured against unauthorized entry.
11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.
11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:
(1) Minimum distance of 6.1 m (20 ft)
(2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems
(3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour
11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12.
11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations.
11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3.
11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations.
11.3.2.8 Cylinder valve protection caps shall comply with 11.6.2.3.
11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12.
11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2.
11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures.

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A 034	Continued From page 9 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. Based on observation and interview, the facility failed to ensure that oxygen cylinder tanks were stored securely and protected from accidental damage. This deficient practice could likely result in the 11 (R #s 1-11) residents identified on the census provided by the Administrator on 05/18/23, to be at risk of harm, injury, or death if oxygen cylinder tanks were to fall over damaging the valve, causing them to depressurize (lose pressure) during a fire, the oxygen feeds the fire, causing it to spread faster and/or the cylinder	A 034		

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A 034	Continued From page 10 tanks act like missiles and hit a resident/staff/rescuer during a fire. The Findings are: A. On 05/18/23 at 8:53 am, during observation of R #7's room: 1. One (1) large unsecured (not in a cart or crate) oxygen cylinder tank 2. One (1) large secured oxygen cylinder tank (in a cart). B. On 05/18/23 at 9:03 am, during an observation of R #5's room: 1. Seven (7) large oxygen unsecured cylinder tanks were observed to between the bedside table and the closet. 2. Four (4) small/short oxygen cylinder tanks were observed to be in a metal container, between the bedside table and the closet. C. On 05/18/23 at 9:27 am, during an observation of R #6's room the following was observed: 1. Four (4) small/short oxygen cylinder tanks were stored in a cardboard box on the floor of the unventilated closet, near combustible (oxygen storage bag, clothing, shoes, plastic laundry basket) materials. 2. One (1) small secured oxygen cylinder tank was stored near combustible materials. D. On 05/18/23 at 9:58 am, during an interview with DCS #2, she confirmed that in R #5's room: 1. Seven (7) large oxygen cylinder tanks were observed to be unsecured between the bedside table and the closet. 2. Four (4) small/short oxygen cylinder tanks were observed to be in a metal container, between the bedside table and the closet.	A 034		

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A 034	Continued From page 11 E. On 05/18/23 at 10:15 am, during an interview with the House Manager, he confirmed the following unsecured oxygen tank findings in R #s 5, 6, 7's resident rooms: 1. One (1) large unsecured and one (1) large secured oxygen cylinder tank was in R# 7's room. 2. Seven (7) large unsecured oxygen tanks were in R #5's room. 3. Four (4) small/short oxygen cylinder tanks were in R #5's room. 4. Four (4) small/short oxygen cylinder tanks were in R# 6's bedroom closet with combustibles. 5. One (1) small oxygen cylinder tank was in R #6's bedroom closet with combustibles. F. On 05/18/23 at 11:35 am, during an interview with the Administrator, he confirmed all the oxygen tank findings listed above.	A 034	A034 The house Manager will conduct room checks. To ensure all rooms are following fire and safety regulations. This practice has been added to the house fire drill training. In addition, oxygen providers have been asked to only provide what is needed and ensure that tanks are kept in secured tank crates.	06/30/2023
{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	{A 035}		

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{A 035}	Continued From page 12	{A 035}		

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.
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

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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}		

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 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;

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{A 035}	Continued From page 14 (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 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]	{A 035}		

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{A 035}	Continued From page 15 This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from survey dated 08/25/23. 7.8.2.35 D G (5) H Based on record review, observation, and interview the facility failed to ensure for 3 (R #s 1, 5, 6) of 3 (R #s 1, 5, 6) residents whose Medication Administration Records (MARs) were reviewed for compliance: 1. Included both the brand and generic names of the medications. 2. That medications are not given to residents without specific orders from the Primary Care Physician. 3. Only a Licensed Nurse (Registered Nurse (RN) or Licensed Practical Nurse (LPN) were administering medications to residents. These deficient practices could likely result in the residents being at risk of harm, illness, or death if: 1. 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. 2. Medications given, that are not listed on the MAR or prescribed by the resident's PCP, could cause the resident to be at risk of harm, injury, or death. 3. Staff that are not Licensed Nurses (RN or LPN), administer medications to residents, could cause the resident to be at risk of harm, injury, or death.	{A 035}		

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{A 035}	Continued From page 16 The Findings are: Findings related to administering medications: A. On 05/18/23 at 9:58 am, during an observation, DCS #2 was observed placing medications into the R #1's mouth. B. On 05/18/23 at 9:58 am, during an interview with DCS #2, she confirmed that: 1. She administered two (2) medications: Tylenol (pain) and [redacted] by physically placing the medications into R #1's mouth. 2. She is not a Licensed Nurse, and has only taken the state-approved course for DCS who assist with the self-administration of medications. 3. She didn't know she was not allowed to administer medications. C. On 05/18/23 at 10:15 am, during an interview with the House Manager, he confirmed that DCS #2 is not a Licensed Nurse, and that she did administer medications to R #1. Findings related to medications not listed on MARs: D. Record review of R #1's MARs dated 04/01/23 through 05/22/23, revealed that [redacted] prescription was not listed on the MAR. E. Record review of Consultant Pharmacist's Medication Regimen Review revealed that [redacted] prescription was discontinued (DC'd), but still being given to R #1. F. Record review of R #1's physician's order received by facility on [redacted]/23, revealed that [redacted] be DC'd effective	{A 035}		

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{A 035}	Continued From page 17 04/05/23. G. On 05/18/23 at 9:58 am, during an interview with DCS #2, she confirmed that she administered [redacted] to R #1; unaware that it had been DC'd. H. On 05/24/23 at 1:48 pm, during an interview with the Administrator, he confirmed that the medication [redacted] (DC'd on [redacted]/23) should not have been still been given to R #1. Findings related to Generic/Brand names on MARs: I. Record Review of R #1's MARs dated 04/01/23 through 05/22/23, revealed that the following medications did not include both the brand/generic names: [redacted] J. Record Review of R #5's MARs dated 04/05/23 to 05/22/23, revealed that the following medications did not include both the brand/generic names: [redacted]	{A 035}		

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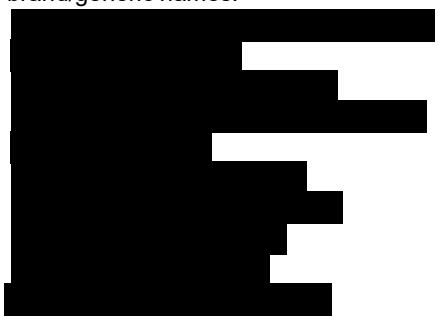
{A 035}	Continued From page 18 K. Record Review of R #6's MARs dated 05/11/23 to 05/22/23, revealed that the following medications did not include both the brand/generic names:  L. Record Review of Consultant Pharmacist's Medication Regimen Review dated 01/01/23 - 01/25/23, revealed that for R #1's MAR: 1. Tylenol (listed on the MAR) needs to say acetaminophen. 2. All medications need both brand name and generic. M. On 05/22/23 at 2:30 pm, during an exit conference interview, the Administrator confirmed that the MARs did not include both brand and generic names.	{A 035}	A 035 The house manager will conduct on-the-spot training on the 6 rights for staff to have ongoing education. Medications will be entered into the EMR with both brand names and to include the generic name as well. By 6/30/2023.	06/30/2023
{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 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.	{A 059}		

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{A 059}	Continued From page 19 (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: This is an uncorrected deficiency from survey dated 08/25/23. 7.8.2.59 B Based on observation and interview, the facility failed to ensure that all operable windows had screens that properly fit the windows. This deficient practice could likely result in the 11 (R #s 1-11) residents identified on the resident census provided by the Administrator on 05/18/23, to be at risk of injury or illness due to bug bites or allergens because the screens on windows had did not fit properly. The findings are: A. On 05/18/23 at 8:27 am, during an observation of the facility, the following windows were found with screens that were bent or did not fit the window properly:	{A 059}		

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{A 059}	Continued From page 20 1. Living room screen bent (¼" gap). 2. Resident Rm #3: screens are bent (gaps). 3. Resident Rm #6: screen did not fit properly (gap). 4. Resident Rm #7: screen was bent (gap). 5. Resident Rm #8: screen did not fit properly (gap). 6. Resident Rm #11: screen was bent (gap). 7. Resident Rm #14: screen was bent (gap). B. On 05/18/23 at 11:35 am, during an interview with the Administrator, he confirmed the above windows had damaged or ill-fitting screens.	{A 059}	A 059 The house manager will coordinate the screens to be fixed and have proper fitment by 07/30/2023 using an outside vender. This will be added to monthly house checks and all findings will be reported to the Administrator.	07/30/2023