Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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 deficiencies were cited during an Initial/Complaint Survey completed on 10/02/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living facilities for Adults. Complaint intake NM [redacted] was investigated and deficiencies were cited. Resident Census: [redacted]	8 000		
8 021	8 NMAC 370.14.21 Resident Records A. Record contents: A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 8.370.14.20 NMAC; (2) the resident evaluation form, that is to be completed within 15 days prior to admission and updated at a minimum of every six months; (3) the current ISP, that is to be completed within 10 calendar days of admission and updated at a minimum of every six months; (4) the physical examination report; the physical examination report shall have been completed within the past six months, by a primary care physician, a nurse practitioner or a physician's assistant and shall be on file in the resident's record within 10 days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and	8 021	R#2's physical exam was completed and filed. All residents were reviewed for current exams within six months. Systemic Fix: The House Manager maintains a Physical Exam Log with due dates. Monitoring: Administrator reviews log monthly for compliance.	11/15/2025

PRINTED: 10/17/2025
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 021	Continued From page 1 phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m)surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the	8 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

(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
8 021	Continued From page 2 original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 8.370.14.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance: (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five years from the date of discharge and readily available within 24 hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [8.370.14.21 NMAC - N, 7/1/2024]	8 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 021	Continued From page 3 This REQUIREMENT is not met as evidenced by: 8.370.14.21 A (4) Based on record review and interview, the facility failed to ensure for 1 (R #2) of 3 (R #'s 1-3) residents whose records were reviewed for complaince had a physicial examination report completed within the past six months by a primary care physician, a nurse practitioner or a physician's assistant. This deficient practice could result in inadequate care planning which could lead to potential harm to the resident if the facility is unaware of the residents current physical capabilities and limitations. The findings are: A. Record review of R #2's resident file revealed there was no physicial examination report completed within the past six months by a primary physican, a nurse practitioner or a physician's assistant. B. On 10/02/25 at 12:39 PM, during an interview, the House Manager confirmed there was no physicial examination report completed within the past six months by a primary care physician, a nurse practitioner or a physician's assistant. 8 NMAC 370.14.25 Resident Evaluation A. A resident evaluation shall be completed by an appropriate staff member within 15 days prior to admission to determine the level of	8 021		
8 025		8 025	Corrective Action: Evaluations for all residents were reviewed and completed to include all required elements. Systemic Fix: Contracted RN will review and sign evaluations every six months. Monitoring: Administrator will verify and	11/16/2025

	assistance that is needed and if the level of services required		audit quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 025	Continued From page 4 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 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 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	8 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE

(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
8 025	Continued From page 5 within six 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 months or when a significant change in health status occurs. [8.370.14.25 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.25 Based on record review and interview the facility failed to ensure for 3 (R #1-3) of 3 (R #1-3) residents whose evaluations were reviewed for compliance included the resident's cognitive abilities, reasoning and perception, the ability to articulate thoughts, memory function or impairment, residents psychosocial wellbeing, etc. As well, that the evaluations were reviewed, and if needed, revised by a Licensed Practical Nurse (LPN), Registered Nurse (RN), or Physician Extender (PE) (a Physician Assistant or Nurse Practitioner). This deficient practice could likely result in staff not implementing the most appropriate care and interventions needed for the resident. The findings are: A. Record review of R #1's Resident Evaluation revealed the evaluation did not contain the level of assistance, a crisis prevention plan, current orders for all medications, psychosocial well-being, activity interests and was not reviewed or revised by an LPN, RN, or PE.	8 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 025	Continued From page 6 B. Record review of R #2's Resident Evaluation revealed the evaluation did not contain the level of assistance, a crisis prevention plan, current orders for all medications, psychosocial well-being, activity interests and was not reviewed or revised by an LPN, RN, or PE. C. Record review of R #3's Resident Evaluation revealed the evaluation did not contain the level of assistance, a crisis prevention plan, current orders for all medications, psychosocial well-being, activity interests and was not reviewed or revised by an LPN, RN, or PE. D. On 10/02/25 at 12:39 PM, during an interview, the House Manager confirmed the evaluations did not contain the level of assistance, a crisis prevention plan, current orders for all medications, psychosocial well-being, activity interests and was not reviewed or revised by an LPN, RN, or PE.	8 025		
8 026	8 NMAC 370.14.26 Individual Service Plan An ISP shall be developed and implemented within 10 calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a	8 026	Corrective Action: All ISPs were updated to include level of assistance, crisis plan, and current medication orders. RN consultant reviewed and signed. Systemic Fix: House Manager ensures completion within 10 days of admission and every six months. Monitoring: Administrator audits quarterly.	11/16/2025

PRINTED: 10/17/2025
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 026	Continued From page 7 minimum of every six months or when there is a significant change in the resident's health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility's determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [8.370.14.26 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure for 3 (R #1-3) of 3 (R #1-3) residents whose Individual Service Plans (ISP) were reviewed for compliance included the resident's cognitive abilities, reasoning and perception, the ability to articulate thoughts, memory function or impairment, residents psychosocial wellbeing, etc. As well, that the evaluations were reviewed, and if needed, revised by a Licensed Practical Nurse (LPN), Registered Nurse (RN), or Physician Extender (PE) (A Physician assistant or Nurse Practitioner).	8 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 026	Continued From page 8 This deficient practice could result in residents not receiving services that meet their current needs or health and safety requirements. The findings are: A. Record review of R #1's ISP revealed it did not contain contain level of assistance, a crisis prevention plan, current orders for all meds, and was not reviewed and if needed, revised by an LPN, RN, or PE. B. Record review of R #2's ISP revealed it did not contain contain level of assistance, a crisis prevention plan, current orders for all meds, and was not reviewed and if needed, revised by an LPN, RN, or PE. C. Record review of R #3's ISP revealed it did not contain contain level of assistance, a crisis prevention plan, current orders for all meds, and was not reviewed and if needed, revised by an LPN, RN, or PE. D. On 10/02/25 at 12:39 PM, during an interview, the House Manager confirmed the ISPs did not contain contain level of assistance, a crisis prevention plan, current orders for all meds, psychosocial well-being, activity interests and were not reviewed by an LPN, RN, or PE.	8 026		
8 031	8 NMAC 370.14.31 Handling of Emergencies A. Upon admission, each resident or surrogate decision maker shall designate a primary care practitioner (PCP) to be called in case of a medical necessity. Each resident or representative shall also designate a concerned person to be called in case of an emergency.	8 031	Corrective Action: Phone relocated to accessible area; emergency contact list posted. Systemic Fix: Monthly inspection by House Manager. Monitoring: Administrator verifies during safety rounds.	10/30/2025

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 031	Continued From page 9 The facility shall establish a policy to secure medical assistance if the resident's own physician is not available. In the event of an illness or an injury to the resident, the PCP or a physician extender shall be notified by the facility. B. The facility shall have a first aid kit that contains at a minimum, gauze, adhesive tape, antiseptic ointment and bandages for emergencies. The first aid kit shall be kept in a designated, easily accessible place within the facility. C. An easily accessible and functional telephone shall be available in each facility for summoning help in case of an emergency. A pay telephone does not fulfill this requirement. D. A list of emergency numbers including: fire department, police department, ambulance services and poison control shall be posted near each public telephone in the facility. [8.370.14.31 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.31 C D Based on observation and interview, the facility failed to ensure there was an easily accessible telephone and a list of emergency phone numbers, including the fire department, police department, ambulance services, and poison control, were posted near the public telephone in the facility. This deficient practice could likely result in the delay of residents receiving emergency medical care and services. The findings are: A. On 10/02/25 at 4:45 PM, during an	8 031	Corrective Action: Phone relocated to accessible area; emergency contact list posted. Systemic Fix: Monthly inspection by House Manager. Monitoring: Administrator verifies during safety rounds.	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
	2903 N WASHINGTON AVE

(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
8 031	Continued From page 10 observation of the public telephone in the office, the telephone was on a shelf behind the desk, not easily accessible to the residents, and a list of emergency numbers was not posted next to the public telephone. B. On 10/02/25 at 4:46 PM, during an interview, the DCS #1 confirmed the phone was not easily accessible to the residents and a list of emergency numbers was not posted next to the public telephone in the library.	8 031		
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	8 032	Corrective Action: All unreported incidents were reviewed, reported, and documented. Staff retrained on reporting timelines. Systemic Fix: Incident Log implemented and reviewed weekly by Administrator. Monitoring: Weekly review and monthly audit for compliance.	11/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 032	Continued From page 11 form for the current year, pursuant to 8.370.9 NMAC; and (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) 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

(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
8 032	Continued From page 12 failed to ensure incidents were reported within twenty-four (24) hours and an investigation was conducted within five (5) business days and reported to the Licensing Authority (LA). This deficient practice could impede (delay or prevent) regulatory oversight and hinder (create difficulties resulting in delay) the identification of care trends or patterns that may affect resident outcomes. The findings are: A. Record review of Resident Incident Log revealed the following: 1. On [redacted]25 at 11:45 AM, a caregiver (no name) assisted a resident (unknown) to the bathroom. They left the resident to get the phone and came back and the resident was on the floor of the bathroom and had a [redacted] on [redacted]head and was not reported to the LA. 2. On [redacted]/25 at 4:00 PM, DCS #2 was assisting R #3 in the shower and noticed a [redacted] and it was not reported within twenty-four (24) hours and an investigation was conducted within five (5) business days and reported to the Licensing Authority (LA). 3. On [redacted]25 at 8:00 AM, DCS #3 was assisting R #4 to sit up in bed and noticed a [redacted] nd was not reported to the LA within twenty-four (24) hours and an investigation was conducted within five (5) business days and reported to the Licensing Authority (LA). 4. On [redacted]25 (no time), DCS #2 went to get R #5 out of bed and noticed [redacted] and was not reported within twenty-four (24) hours and an investigation was conducted within five (5) business days and reported to the Licensing Authority (LA).	8 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 032	Continued From page 13 5. On [redacted]25 (no time) DCS #2 was going to take R #5 to shower and noticed [redacted] and was not reported within twenty-four (24) hours and an investigation was conducted within five (5) business days and reported to the Licensing Authority (LA). 6. On [redacted]/25, (no time), DCS #2 was taking R #6 to the shower and noticed [redacted] and was not reported within twenty-four (24) hours and an investigation was conducted within five (5) business days and reported to the Licensing Authority (LA). B. Record review of Narrative Note dated [redacted]25 at 8:18 AM revealed DCS #3 and 4 were asked to take R #8's [redacted] and as they were helping to take [redacted] The caregivers cleaned the [redacted] and applied steri-strips and medicated gauze. The incident was not reported within twenty-four (24) hours and an investigation was conducted within five (5) business days and reported to the Licensing Authority (LA). C. Record review of daily log note dated [redacted]/25 at 8:30 AM made by DCS #6 revealed R #7 [redacted] and lost consciousness. [redacted] regained consciousness and continued eating. [redacted] finished [redacted] food and was taken to [redacted] room and sat in [redacted] recliner and did a [redacted] This incident was not reported within twenty-four (24) hours and an investigation was conducted within five (5) business days and reported to the Licensing Authority (LA). D. On 10/01/25 at 2:18 PM, during an interview, the administrator confirmed the	8 032		

	aforementioned (previously mentioned) incendents were not			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 032	Continued From page 14 reported within twenty-four (24) hours or an investigation was conducted within five (5) business days and reported to the Licensing Authority (LA)	8 032		
8 034	8 NMAC 370.14.34 Custodial Drug Permits A facility with two 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.	8 034	Corrective Action: All cylinders secured with chains/stands and relocated. "Oxygen in Use" signage posted. Systemic Fix: Updated oxygen storage policy and daily checks. Monitoring: Weekly inspection by House Manager; monthly verification by Administrator	10/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

(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
8 034	Continued From page 15 (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 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	8 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 034	Continued From page 16 oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within 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 8.370.14 NMAC. [8.370.14.34 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.34 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.	8 034		

	11.3.2.1 Storage locations shall be outdoors in an			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 034	Continued From page 17 enclosure or within an enclosed interior space of noncombustible or limited combustible 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	8 034		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

(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
8 034	Continued From page 18 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 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) 99.11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures: (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. Based on observation and interview the facility failed to ensure oxygen cylinder tanks were stored in a secure location protected from accidental damage or dislocation. These deficient practices could potentially affect	8 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 034	Continued From page 19 the health, safety, and welfare of residents if oxygen cylinder tanks were to fall over, damaging the valve, causing it to depressurize (release the pressure of the gas inside) during a fire; the oxygen feeds the fire, causing it to spread faster. The finding are: A. On 09/30/25 at 4:16 PM, during an observation of the facility, one (1) unsecured cylinder oxygen tank was observed in the hallway next to [redacted] B. On 09/30/25 at 4:17 PM, during an interview, the House Manager confirmed the unsecured oxygen cylinder tank was in the hallway next to [redacted] C. On 09/30/25 at 4:30 PM, during an observation of the facility's two car garage, (1) one large unsecured oxygen cylinder tank was standing on the floor approximately (4) feet from the facilities (2) two fuel fired hot water heaters. D. On 09/30/25 at 4:40 PM, the House Manager confirmed that (1) one large unsecured oxygen cylinder tank was standing on the floor approximately (4) feet from the facilities (2) two fuel fired hot water heaters. E. On 10/01/25 at 1:52 PM, during a observation of [redacted] two unsecured oxygen cylinder tanks were observed unsecured and improperly stored in a fabric storage box on the ground, and there was no oxygen is use signage on the door. F. On 10/02/25 at 12:39 PM, the House Manager confirmed the unsecured oxygen cylinder tanks in [redacted] that were	8 034		

	improperly stored and there was no oxygen in use signage on the door.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 035	8 NMAC 370.14.35 Medication 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. 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.	8 035	Corrective Action: MARs updated for all residents to include all required information. Systemic Fix: Medication Coordinator and House Manager will ensure all new MARs contain full details. Monitoring: Administrator and consulting RN will review MARs monthly.	11/18/2025

Division of Health Improvement

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

NAME OF PROVIDER OR SUPPLIER

BEEHIVE HOMES OF ROSWELL

STREET ADDRESS, CITY, STATE, ZIP CODE

2903 N WASHINGTON AVE

ROSWELL, NM 88201

(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
8 035	Continued From page 21 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 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;	8 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 035	Continued From page 22 (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 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	8 035		

	in the original container with a pharmacy label that includes the following: (1) the resident's name;			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 035	Continued From page 23 (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. [8.370.14.35 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.35 G (5) (12) (17) Based on record review and interview, the facility failed to ensure for 3 (R #'s 1-3) of 3 (R #'s 1-3) residents whose Medication Administration Record (MAR) were reviewed for compliance that the medications listed on the MAR contained: 1. Both brand and generic name. 2. The date that the medication was started or discontinued. 3. The desired results obtained from or problems encountered with the medication (pain relieved, etc.) These deficient practices could likely result in the [redacted] residents listed on the resident census provided by the House Manager on 09/30/25, to be at risk of illness or harm if: 1. Medication errors occur when a Direct	8 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

(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
8 035	Continued From page 24 Care Staff (DCS) accidentally gives the wrong medication to a resident if the name of the medication listed does not include both brand and generic names. 2. Medication errors occur when medications listed on the MAR do not list the dates they were started and discontinued. 3. Desired results or problems encountered are not documented. The findings are: A. Record review of R #1's August 2025 MAR revealed it did not contain the following: 1. Both brand and generic name. 2. The date that the medication was started or discontinued. 3. The desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.) B. Record review of R #2's July 2025 MAR revealed it did not contain the following: 1. Both brand and generic name. 2. The date that the medication was started or discontinued. 3. The desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.) C. Record review of R #3's August 2025 MAR revealed it did not contain the following: 1. Both brand and generic name. 2. The date that the medication was started or discontinued. 3. The desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.) D. On 10/09/25 at 3:43 PM, during an interview,	8 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 035	Continued From page 25 DCS #8 confirmed R #'s 1-3 MARs did not contain the aforementioned (mentioned previously) information.	8 035		
8 036	8 NMAC 370.14.36 Nutrition The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the "recommended daily dietary allowance" of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the "2005 USDA dietary guidelines for Americans." Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures: The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service: The facility shall: (a) serve at least three meals or their equivalent each day at regular times with no more than 16 hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one week cycle; (e) have special menus or meal items following	8 036	Corrective Action: New weekly menus posted with snacks and substitutions; thermometers placed in refrigerator/freezers; expired food discarded; pantry cleaned. Systemic Fix: House Manager will ensure daily temperature logs are completed and menus rotated weekly. Monitoring: Administrator reviews food safety logs weekly.	11/08/2025

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 036	Continued From page 26 guidelines from the resident's physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident's PCP within 48 hours if a resident consistently refuses to eat. (2) Staff in-service training: The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records: The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for 30	8 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

(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
8 036	Continued From page 27 calendar days. C. Clean and sanitary conditions: All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation: (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware: (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels.	8 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 036	Continued From page 28 (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management: The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction. (1) The facility shall ensure that a minimum of a three calendar day supply of perishables and a five calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be 35 - 41 degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food.	8 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 036	Continued From page 29 Hot food temperatures shall be checked periodically to insure that a minimum of 140 degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than 41 degrees fahrenheit; (b) the temperature for all hot foods is maintained at 140 degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk: (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as "additives" in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements: Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal	8 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

(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
8 036	Continued From page 30 regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [8.370.14.36 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.36 A (1) (a) (c) B (4) C (1) D (2) Based on record review, observation, and interview, the facility failed to ensure the weekly food menu was posted and included substitutions and snacks and identical menus were not used within a one week cycle, the refrigerators and freezer had thermometers, daily temperature logs of the refrigerator and freezers were maintained, expired foods were discarded, and the kitchen pantry was maintained in a clean and sanitary manner. These deficient practices could likely cause residents to be unaware of what meal substitutions and snacks are available and be limited on meal options each week, or to become ill if the kitchen is not maintained in a sanitary manner, foods are not kept at the right temperature, and expired foods are not discarded. The findings related to the Menu are: A. On 09/30/25 at 3:55 PM, during a tour of the facility inside grounds revealed there was no menu posted for residents to view. Only menu posted was inside the kitchen on the refrigerator.	8 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 036	Continued From page 31 B. Record review of the facility's menu for the week 09/08/25 revealed the following: 1. Eggs, bacon, toast, fruit, coffee, and juice listed on Monday, Tuesday, Thursday and Saturday. 2. Pancakes, sausage, fruit, coffee, and juice listed on Wednesday and Sunday. 3. Oatmeal, bacon, toast, muffins, coffee, and juice listed for Friday. 4. No substitutions listed. 5. No snacks listed. 6. Hand written for lunch and dinner. C. Record review of the facility's menu for the week 09/15/25 revealed the following: 1. Eggs, bacon, toast, fruit, coffee, and juice listed on Monday, Tuesday, Thursday and Saturday. 2. Pancakes, sausage, fruit, coffee, and juice listed on Wednesday and Sunday. 3. Oatmeal, bacon, toast, muffins, coffee, and juice listed for Friday. 4. No substitutions listed. 5. No snacks listed. 6. Hand written for lunch and dinner. D. Record review of the facility's menu for the week 09/22/25 revealed the following: 1. Eggs, bacon, toast, fruit, coffee, and juice listed on Monday, Tuesday, Thursday and Saturday. 2. Pancakes, sausage, fruit, coffee, and juice listed on Wednesday and Sunday. 3. Oatmeal, bacon, toast, muffins, coffee, and juice listed for Friday. 4. No substitutions listed. 5. No snacks listed. 6. Hand written for lunch and dinner.	8 036		

	E. Record review of the facility's menu for the			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 036	Continued From page 32 week 09/29/25 revealed the following: 1. Eggs, bacon, toast, fruit, coffee, and juice listed on Monday, Tuesday, Thursday and Saturday. 2. Pancakes, sausage, fruit, coffee, and juice listed on Wednesday and Sunday. 3. Oatmeal, bacon, toast, muffins, coffee, and juice listed for Friday. 4. No substitutions listed. 5. No snacks listed. 6. Hand written for lunch and dinner. F. On 09/30/25 at 3:57 PM, during an interview, the House Manager confirmed the weekly menu was not posted and included substitutions and snacks and identical menus were not used within a one week cycle. Findings related to the freezer and pantry: G. On 10/01/25 at 1:40 PM, observation of the pantry refrigerator with freezer located in the food pantry revealed: 1. No thermometers in the refrigerator or freezer. 2. No daily temperature logs of the refrigerator or freezer daily temperatures. H. On 10/01/25 at 1:43 PM, observation of the kitchen's food pantry shelves revealed: 1. (1) one box of cinnamon bread mix with a "Use by Date" of June 14, 2020. 2. (1) one approximately fourteen (14) inch in diameter metal skillet used for cooking residents' food, that was filled with a previously used brown colored cooking oil with a strong odor and food debris floating in it.	8 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 036	Continued From page 33 I. On 10/01/25 at 1:46 PM, the facilities cook confirmed: 1. There were no thermometers in the pantry refrigerator or freezer 2. There were NO daily temperature logs of the refrigerator or freezer daily temperatures available for review. 3. That (1) one box of cinnamon bread mix had a "Use by Date" of June 14, 2020, was 7 years past its use by date, and was on the pantry shelf, available to be cooked and served to residents. 4. There was (1) one approximately fourteen (14) inch in diameter metal skillet used for cooking residents' food, that was filled with a previously used brown colored cooking oil with a strong odor and food debris floating in it.	8 036		
8 037	8 NMAC 370.14.37 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 layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable	8 037	Corrective Action: A door lock with code entry was installed. Systemic Fix: Laundry room policy updated to require all hazardous materials remain locked when not in use. Monitoring: House Manager checks daily; Administrator audits monthly.	10/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 037	Continued From page 34 alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than 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. [8.370.14.37 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.37 A 10 Based on observation and interview, the facility failed to ensure cleaning supplies and hazardous chemicals (any chemical that presents as a health hazard or can cause physical harm) were stored in secured areas and were not accessible to residents.	8 037		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 037	Continued From page 35 This deficient practice could likely result in the residents to be at risk of harm, illness, or injury if the residents were to spill or ingest (take food, liquids, or other substances in the body by swallowing or absorbing it) cleaning supplies and/or hazardous chemicals and sustain injuries, burns, blisters, and possible blindness or other harm. The finding are: A. On 09/30/25 at 3:48 pm, during an observation of the Laundry room, the door was unlocked and open and unsecured chemicals in the cabinets and under the sink including: 1. In the cabinet across from washer was (1) quart of wood stain. 2. Under the sink was: a. (1) gallon can of paint b. (1) gallon floor cleaner c. (2) 33.8 Hand sanitizer refills B. On 09/30/25 at 3:52 pm during an interview, the Administrator confirmed the unsecured cleaning supplies and hazardous chemical findings for the facility Laundry Room. 8 NMAC 370.14.38 Housekeeping Services The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or	8 037		
8 038		8 038	Corrective Action: Chemicals in kitchen secured with cabinet door locks. Systemic Fix: Chemical safety policy updated and all kitchen staff retrained. Monitoring: House Manager inspects weekly; Administrator verifies during safety rounds.	10/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

(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
8 038	Continued From page 36 flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [8.370.14.38 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.38 C Based on observation and interview, the facility failed to ensure chemicals and poisonous substances were not stored in or near residential areas and were not accessible to residents. This deficient practice could likely result in the residents to be at risk of harm, illness, or injury if the residents were to spill or ingest (take food, liquids, or other substances in the body by swallowing or absorbing it) cleaning supplies and/or hazardous chemicals and sustain injuries, burns, blisters, and possible blindness or other harm. The findings are: A. On 10/01/25 at 1:56 pm during observation of the facility kitchen, the following chemicals were observed in the cabinets: 1. Under the large kitchen sink: a. (1) 1 gallon bottle of hand soap. b. 32 ounce spray bottle of disinfectant cleaner.	8 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 038	Continued From page 37 c. 38 ounce bottle of dishwasher rinse. d. 20 ounce container of dishwasher detergent booster. e. 125 ounce bottles of dishwasher detergent. f. 90 ounce bottle of dishwashing liquid. 2. Under the small kitchen sink: a. (1) 32 ounce unlabeled bottle of an unidentified yellow liquid. b. (2) 19 ounce spray cans of oven and grill cleaner c. (1) 16 ounce bottle of ice machine cleaning solution. d. (1) 19 ounce can of stainless steel cleaner and polish. e. (1) 32 ounce spray bottle of odor eliminator. f. (1) 32 ounce spray bottle of oven, grill and fryer cleaner. g. (1) 32 ounce bottle of green cleaning solution. h. (1) pint can of wood stain i. (1) 85 count container of disinfecting wipes. B. On 10/01/25 at 2:05 PM, during an interview the facilities Cook, he confirmed that there were chemicals stored in the unsecured cabinets under the large and small kitchen sinks.	8 038		
8 043	8 NMAC 370.14.43 Hazardous Areas Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than 100 sq. ft., storage rooms more than 50 sq. ft. but less than 100 sq. ft. not storing combustibles, storage rooms with more than 100 sq. ft. storing combustibles, chemical storage rooms with more than 50 sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and	8 043	Corrective Action: All holes in garage walls and ceilings repaired; flammable and oxygen materials relocated beyond six-foot safety zone. Systemic Fix: Maintenance schedule established for quarterly inspection of all hazardous areas. Monitoring: Administrator verifies fire-safety compliance monthly.	11/12/2025

	in or abutting, a primary means of escape or a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 043	Continued From page 38 sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter of an hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or (3) other hazardous areas shall be enclosed with walls with at least a 20 minute fire rating and doors equivalent to one and three-quarter inches solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms: For facilities with four or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one hour. Doors to these rooms shall be one and three-quarter inches solid core. [8.370.14.43 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.43 A (3) B Based on observation and interview, the facility failed to ensure that hazardous areas abutting (next to) a sleeping room were protected by an enclosure of at least a one hour fire rating, the garage ceiling was free from perforations, and toxic or flammable liquids were not stored within six feet of gas fueled water heaters. These deficient practices could likely cause harm to residents if a fire were to occur in the garage and was able to spread quickly to nearby bedrooms, the roof, or other parts of the facility	8 043		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

(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
8 043	Continued From page 39 and if flammable chemicals were to accelerate a fire if they were stored near a fuel fired water heater. The findings are: A. On 09/30/25 at 4:30 pm, during an observation of the facility's garage, the following was observed on the northeast wall of the garage behind the water heater which is abutted resident sleeping rooms: 1. (1) one approximately (10) ten inch wide by (5) five foot long perforation (hole) in the sheetrock wall. 2. (1) One approximately 3/4 inch wide perforation in the wall where a metal pipe from the hot water heater entered the wall. B. On 09/30/25 at 4:30 pm, during an observation of the garage ceiling, the following perforations were found: 1. Above the (2) two hot water heaters there was a 1/4 inch wide perforation around a metal pipe connected to the hot water heaters. 2. Near the electric garage door opener mechanism attached to garage ceiling was a (2) two foot by (2) two foot square perforation in the ceiling. 3. At numerous (unidentified number) of connection points where the metal garage door track attachment anchors were attached to the ceiling there were ½ (one-half inch) to 2 (two inch) sized perforations in the ceiling. C. On 09/30/25 at 4:45 pm, during an observation of the facility garage, the following was observed stored within (6) six feet of the (2) two gas fueled hot water heaters: 1. (1) one, 1- quart can of house paint. 2. (1) one gasoline fueled lawn mower with	8 043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 043	Continued From page 40 gasoline in it's fuel tank. 3. (1) one unsecured large oxygen canister/tank. 4. (6) six aerosol spray cans of glass cleaner. 5. (6) six aerosol spray cans of air freshener spray. 6. (1) one, 1- pint can of wood stain. 7. (1) one, 1- gallon container of hand sanitizer. 8. (6) six, 32- ounce bottles of disinfectant cleaner. 9. (1) one, 1- gallon of bottle of multi purpose cleaner. 10. (6) six, 1- gallon bottles of bleach. 11. (1) one, 1- gallon bottle of drain cleaner. D. On 09/30/25 at 4:40 PM, the House Manager confirmed the perforations in the garage and the unsecured oxygen, flammable chemicals, and gasoline-fueled lawn mover stored within 6 feet of the 2 gas fueled water heaters.	8 043		
8 045	8 NMAC 370.14.45 Water Pursuant to the current New Mexico drinking water requirements: 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 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	8 045	Corrective Action: Water heater thermostats adjusted to maintain 95–110°F. All faucets re-tested for compliance. Systemic Fix: Maintenance will check water temperature weekly. Monitoring: Administrator reviews logs monthly.	10/28/2025

	systems by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 045	Continued From page 41 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 95 degrees fahrenheit and a maximum of 110 degrees fahrenheit. Hot water in excess of 110 degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury. [8.370.14.45 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.45 E Based on observation and interview, the facility failed to ensure the resident bathroom hot water temperatures were maintained at a minimum of 95 degrees fahrenheit and a maximum of 110 degrees fahrenheit. This deficient practice could likely cause the [redacted] residents (R #'s 1-[redacted] listed on the census provided by the House Manager on 09/30/25, to be at risk of burns from water that is above set standards. The findings are: A. On 10/01/25 at 1:36 PM, during observation of [redacted] bathroom faucet water temperature revealed a temperature of 123.6 degrees Fahrenheit. B. On 10/01/25 at 1:38 PM, during observation of	8 045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

(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
8 045	Continued From page 42 Room [redacted] bathroom faucet water temperature revealed a temperature of 124.3 degrees Fahrenheit. C. On 10/01/25 at 1:41 PM, during observation of Room [redacted] bathroom faucet water temperature revealed a temperature of 122.3 degrees Fahrenheit. D. On 10/01/25 at 2:22 PM, during an interview, the Administrator confirmed Room #'s [redacted] bathroom faucet water temperature was above 120 degrees Fahrenheit.	8 045		
8 047	8 NMAC 370.14.47 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 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 or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected	8 047	Corrective Action: Defective emergency light replaced and tested. Systemic Fix: Monthly emergency light testing log created. Monitoring: Administrator reviews log monthly to ensure full function of all units.	10/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 047	Continued From page 43 emergency lighting. [8.370.14.47 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.47 E Based on observation and interview, the facility failed to ensure emergency lights were in working order. This deficient practice could impede (delay or prevent) residents, staff, and other occupants from safe evacuation of the facility if a fire or other emergency occurred and residents were not able to see to exit the building. The findings are: A. On 09/30/25 at 3:46 pm, during observation of the facility, upon testing the facility's emergency lights, one (1) emergency light on the southeast side of the building in the hallway near the linen closet was flashing on and off when tested and seemed to be shorting out (having a bad electrical connection that is disrupting the power supply). B. On 09/30/25 at 4:02 pm, during an interview, the Administrator confirmed the emergency light was not in working order when tested.	8 047		
8 052	8 NMAC 370.14.52 Corridors A. Corridors in an existing building shall have a minimum width of 36 inches. Corridors in newly constructed facilities shall have a minimum width	8 052	Corrective Action: All items removed from hallway; corridor cleared. Systemic Fix: Staff re-educated on corridor safety policy. Monitoring: Daily visual checks by House Manager;	10/24/2025

			monthly safety audits by Administrator.	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 052	Continued From page 44 of 44 inches. B. Corridors shall have a clear ceiling height of not less than seven feet measured to the lowest projection from the ceiling. C. Corridors shall be maintained clear and free of obstructions at all times. D. The floors of corridors and hallways shall be waterproof, greaseproof, smooth, slip-resistant and durable. [8.370.14.52 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.52 C Based on observation and interview, the facility failed to ensure corridors were maintained free and clear of obstructions at all times. This deficient practice could potentially lead to delays and/or inability for residents utilizing corridors to exit the facility safely in cases of an emergency. The findings are: A. On 09/30/25 at 4:25 pm during an observation of the facility the corridor outside of Resident [redacted], the following items were stored near the entry door that presented as an obstruction and tripping hazard: 1. (1) one approximately (24) twenty-four inch tall by (16) sixteen inch wide plastic and cloth bag filled with plastic bowling pins and bowling balls. 2. (2) two approximately (24) twenty-four inch high by (16) sixteen inch wide by (18) eighteen inch deep (3) three drawer plastic containers. 3. One (1), 1152 count box of body wipes sitting on top of the three drawer plastic containers.	8 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
	2903 N WASHINGTON AVE

(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
8 052	Continued From page 45 4. (8) 3 foot long multi-color foam tubes leaning on one of the three drawer containers. B. On 09/30/25 at 4:25 pm, during an interview, the House Manger confirmed obstructions in the corridor outside of [redacted]	8 052		
8 059	8 NMAC 370.14.59 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 20 inches wide minimum and measured 24 inches high minimum. (2) The top of the window sill shall not be more than 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 of the floor area with a minimum of 10 square feet. [8.370.14.59 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.59 A (1) Based on observation and interview, the facility failed to ensure that all the facility's windows were equipped with functional window screens. This deficient practice could likely result in the [redacted] residents identified on the census provided by the House Manager on 09/30/25, to be at risk of	8 059	Corrective Action: All damaged and missing screens replaced or repaired. Systemic Fix: Maintenance schedule implemented for quarterly inspection of windows and screens. Monitoring: Administrator reviews quarterly maintenance reports.	11/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 059	Continued From page 46 illness if they are exposed to bugs/insects, allergens (dust/dirt), or debris (leaves or other fragments) coming in through the bowed (curved or distorted shape) window screens. The findings are: A. On 09/30/25 at 5:04 PM, during observation of the exterior of the facility revealed the following: 1. Window #1 on the Southeast (SE) side of the building was torn and frayed. 2. Window #'s 1, 2, 3, 4, 5, 6, and 8 on the Northeast (NE) side of the building were torn and frayed; window #7 was missing a screen. 3. Window #1 on the Northwest (NW) side of building was torn and frayed; window #2 was torn, frayed, and had a broken frame. B. On 10/01/25 at 8:34 AM, during an interview, the Maintenance worker confirmed the window screens were torn, frayed, and one with a broken frame.	8 059		
8 063	8 NMAC 370.14.63 Fire Extinguishers Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two 2A10BC fire extinguishers: (1) one extinguisher located in the kitchen or food preparation area; (2) one extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be 50 feet.	8 063	Corrective Action: All extinguishers inspected and documented; new monthly inspection log established. Systemic Fix: Fire safety procedures updated to include monthly visual inspection and annual professional servicing. Monitoring: House Manager performs monthly inspection; Administrator verifies documentation quarterly.	10/31/2025

PRINTED: 10/17/2025
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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
8 063	Continued From page 47 B. Fire extinguishers, alarm systems, automatic detection equipment and other firefighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [8.370.14.63 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: NM 8.370.14.63 B Reference NAPA 10, Standard for Portable Fire Extinguishers, 1998 Edition: 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Based on observation and interview, the facility failed to ensure fire extinguishers were being inspected monthly as recommended by the manufacturer. This deficient practice could likely result in residents, staff members, and other building occupants to be at risk of harm, injury, or death if a fire were to occur and the fire extinguishers did not work. The findings are: A. On 09/30/25 at 3:43 PM, during observation of the facility's fire extinguishers, three (3) fire extinguishers had not been inspected monthly	8 063		

	as recommended by the manufacturer: 1. One (1) fire extinguisher located outside the kitchen last annual inspection by the fire			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7363	A. BUILDING: _____ B. WING _____	C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ROSWELL	2903 N WASHINGTON AVE ROSWELL, NM 88201

(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

8 063	Continued From page 48 Marshall was performed in April 2024. The monthly inspections were only from 06/2025 to 08/2025. No previous monthly inspections. 2. One (1) fire extinguisher located in the kitchen last annual inspection by the fire Marshall was performed April 2024. The monthly inspections were only from 06/2025 to 08/2025. No previous monthly inspections. 3. One (1) fire extinguisher located by the dining room last annual inspection by the fire Marshall was performed in April 2024. The monthly inspections were only from 06/2025 to 08/2025. No previous monthly inspections. B. On 09/30/25 at 4:02 PM, during an interview, the facility House Manager confirmed the respective fire extinguishers in the facility had not been inspected monthly by staff and the annual inspection was last performed by the fire Marshall April 2024.	8 063		