STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2179	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF SANTA FE	3838 THOMAS ROAD SANTA FE, NM 87507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Full-Onsite/Complaint survey completed on 10/27/22, for the state requirements of 7.8.2. NMAC Regulations for Assisted Living Facilities for Adults. Complaint Intake ID #NM 00049972 was unsubstantiated with no deficiencies cited. Complaint Intake ID #NM 00059942 was unsubstantiated with deficiencies cited. Complaint Intake ID #NM 00061420 was unsubstantiated with deficiencies cited. ABBREVIATIONS: 1. Resident: R 2. New Mexico: NM 3. Assisted Living Facility: ALF 4. Direct Care Staff: DCS 5. Activities of Daily Living: ADLs 6. Individual Service Plan: ISP 7. Employee Abuse Registry: EAR 8. Caregiver Criminal History Screening Program: CCHSP 9. History and Physical: H&P 10. Power of Attorney: POA 11. Incident Report: IR 12. Registered Nurse: RN 13. Licensed Practical Nurse: LPN 14. Certified Nurse Practitioner: CNP 15. Physicians Extender: PE 16. Policy and Procedure: P/P 17. Emergency Medical Services: EMS 18. Emergency Room: ER 19. Centimeters: cm 20. Fahrenheit: F 21. fluid ounces: fl oz 22. microgram: mcg 23. milligrams: mg 24. New Mexico Administrative Code: NMAC	A 000		

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A 000	Continued From page 1 25. New Mexico Department of Health - Division of Health Improvement: NM DOH - DHI 26. m: meter 27. ft: feet	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant	A 016		

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A 016	Continued From page 2 training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 016		

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A 016	Continued From page 3 7.8.2.16. B (3) (7) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry,	A 016		

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A 016	Continued From page 4 including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006]	A 016		

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A 016	Continued From page 5 Refer to 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions.	A 016		

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A 016	Continued From page 6 The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each	A 016		

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A 016	Continued From page 7 applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility failed to ensure: 1. DCS received clearances from the EAR prior to their hire dates. 2. DCS had their applications and fingerprints for the CCHSP submitted within 20 days of hire. This deficient practice could likely have a negative affect on the safety and welfare of the 10 (R #s 1, 2,4, 7-13) residents identified on the census provided by the Operations Manager on 10/03/22, if residents are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents and who may have a previous criminal history. The findings are: A. Record review of the Administrator's employee file (hire date 05/2020, no specific date provided) revealed: 1. The EAR clearance was not completed until 04/09/21.	A 016	A 016 7 NMAC 8.2.16 Staff Qualifications The corrective action will include the following: The Operations Manager or the Assistant Manager will complete the process for the Employment Abuse Registry (EAR) and monitor all new hire processes. A face sheet will be included in a file, for any potential new hires, identifying when the EAR has been cleared. This face sheet, as well as the printed copies of the cleared EAR documents will be will be signed	12/22/2022

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A 016	2. The application for fingerprints was not on file. 3. The CCHSP clearance letter was not received until 04/09/21 Continued From page 8 B. On 10/27/22 at 10:19 am, during an interview with the Administrator and Operations Manager, she confirmed that the EAR and CCHSP clearances for the Administrator were not completed timely.	A 016	A 016 7 NMAC 8.2.16 Staff Qualifications Continued and dated by the Managers, to be filed in the new hire's binder. This corrective action will prevent the possibility of any new employee beginning their first training day, without the EAR clearance documents. The Operations Manager or the Assistant Managers will complete the process for the fingerprint application and monitor all the new hire processes. The fingerprint application will be included in a new employee's file. The document will include the Managers signature and date. This process will prevent any possibility, of any new employee, working under the Provider to remain in employment. The Operations manager will monitor the Caregiver Criminal History Screening Program (CCHSP) by completing the afore mentioned face sheet, with his/her signature and initials, within the date provided on the CCHSP document. Once an employee is cleared/ denied this document shall remain within the employee's file. This will process will prevent any possibility, of any new employee, to remain working after the CCHSP's defined date with their clearance results.	12/22/2022
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems;	A 025		

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A 025	Continued From page 9 (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 within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A. B. Based on record review and interview the facility failed to ensure for 4 (R #s 1, 2, 4 and 6) of 6 (R	A 025		

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A 025	Continued From page 10 #s 1-6) residents whose "Evaluations" were reviewed for compliance that: 1. They were completed within fifteen (15) days prior to admission. 2. They were reviewed and if needed updated at a minimum of every 6 months or when there is a significant change in health status. These deficient practices could potentially affect the health, safety, and welfare of residents if: 1. The resident's initial baseline Evaluation was not done prior to admission to determine the level of assistance needed and if the level of services required can be met by the facility. 2. The resident's Evaluations are not reviewed and/or updated as required so Direct Care Staff (DCS) are knowledgeable and providing the resident with the level of assistance that is required according to the Evaluation. The findings related to R #1, and 2 are: A. Record review of R #1's facility record revealed that: 1. R #1 admission date was [redacted]/22, and the initial evaluation was completed on 02/03/22. 2. R #1's record revealed that there was no documentation of any follow up evaluations being completed at a minimum of every six (6) months. B. Record review of R #2's facility record revealed that: 1. R #2 admission date was [redacted]/20, and the initial evaluation was completed on [redacted]/20, which was not completed within 15-days prior to admission. 2. R #2's record revealed there was no documentation of any follow up evaluations being completed at a minimum of every 6 months.	A 025	A025 7 NMAC 8.2.25 Resident Evaluation The Operations Manager or the Assistant Manager will be responsible for confirming that the evaluation shall be completed within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the Resident can be met by the facility. A document will be created to identify the date of the evaluation, including the Managers signature and date. This document will be filed in the Resident's binder under "Resident Evaluation." The Operations manager and the Assistant Manager will monitor all new Resident's binders upon the admission to the facility to ensure ongoing compliance.	12/22/2022

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A 025	Continued From page 11 The findings related to R #4 are: C. Record review of R #4's facility record revealed that: 1. R #4's admission date was [redacted]/21, and the initial evaluation was completed on 09/22/21. 2. R #4's record revealed there was no documentation of any follow up evaluations being completed at a minimum of every 6 months. The findings related to R #6 are: D. Record review of R #6's facility record revealed that: 1. R #6's admission date was [redacted]/21 and the initial Evaluation was completed on 12/07/21. 2. There was no documentary evidence that an Evaluation was done at a minimum of every 6 months. E. On 10/27/22 at 10:38 am, during an interview with the facility's Operations Manager at the exit conference, she confirmed that: 1. The resident Evaluation for R #s 2 had not been completed within 15-days prior to admission and had not been updated at a minimum of every 6 months. 2. The facility did not do an Evaluation for R #1, 4 and 6 at a minimum of every 6 months.	A 025	A025 7 NMAC 8.2.25 Resident Evaluation Continued The Operations Manager and the Assistant Manager will create a binder to include every current Resident with their Six-Month Evaluation date. The facility will monitor the corrective action and ensure ongoing compliance with the assistance of this binder to be reviewed daily, by the Caregivers beginning their shift at 07:00 every morning. The Operations Manager will be responsible for confirming that the evaluation shall be completed by herself, or the Assistant Manager within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the Resident can be met by the facility. A document will be created to identify the date of the evaluation, including the Operations Manager signature and date. This document will be filed in the Resident's binder under "Resident Evaluation." The Operations manager will monitor all new Resident's binders upon the admission to the facility to ensure ongoing compliance daily.	12/22/2022
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as	A 026		

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A 026	Continued From page 12 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 minimum of every six (6) 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. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 026		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF SANTA FE	3838 THOMAS ROAD SANTA FE, NM 87507

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A 026	Continued From page 13 7.8.2.26 Based on record review and interview the facility failed to ensure for 1 (R # 2) of 6 (R #'s 1 - 6) residents whose records were reviewed for compliance that their Individual Service Plans (ISPs) were developed and implemented within (10) calendar days of admission. This deficient practice could likely negatively affect the health, safety, and welfare of residents, if their ISP's were not being created, reviewed, and revised as required to ensure the DCS are providing the correct care and services to the residents. The findings are: A. Record review of R #2's [redacted] dated [redacted]/20, revealed no documented evidence that an initial [redacted] was developed and implemented within (10) calendar days of admission on [redacted]/20. B. On 10/27/22 at 10:40 am, during the exit conference with the Operations Manager, she confirmed the findings above.	A 026	A 026 7 NMAC 8.2.26 Individual Service Plan The Operations Manager will confirm that an ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A face sheet inside every Resident's binder will provide a checklist to ensure this date is met. The Operations Manager's signature and date will be provided on this checklist. The facility will monitor the corrective action by a daily review of the new Resident's binder ensuring ongoing compliance.	12/22/2022
A 027	7 NMAC 8.2.27 Resident Activities RESIDENT ACTIVITIES: Each facility shall provide or make available recreational and social activities appropriate to the residents ' abilities that meet their psychosocial needs and are relevant to their social history; including a balance of cognitive, reminiscence, physical and social activities. The facility shall post the activities and encourage residents to participate. [7.8.2.27 NMAC - Rp, 7.8.2.28 NMAC, 01/15/2010]	A 027		

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A 027	Continued From page 14 This REQUIREMENT is not met as evidenced by: 7.8.2.27 Based on observation and interview the facility failed to ensure that a resident activities calendar that meets the resident's needs was posted so resident, families, and visitors would know which activities were available. This deficient practice could likely affect the mental and social well-being of the 10 (R #s 1, 2,4, 7-13) residents identified on the census, provided by the Operations Manager on 10/03/22, if the residents are not aware of what activities are available. The findings are: A. On 10/04/22 at 10:41 am, during observation of the facility, no activities calendar was found. B. On 10/04/22 at 10:41 am, during an interview with the Operations Manager, she confirmed that the facility did not post an activities calendar for residents.	A 027	A 027 7 NMAC 8.2.27 Resident Activities The Assistant Manager will provide an activities calendar, posted on a board, beside the sign-in sheet. The facility will monitor the corrective action by posting at least two activities calendars simultaneously on this board.	12/22/2022
A 031	7 NMAC 8.2.31 Handling of Emergencies 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. 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	A 031		

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A 031	Continued From page 15 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. [7.8.2.31 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.31 D Based on observation and interview, the facility failed to ensure that a list of emergency contact phone numbers was posted near the public phone for residents, family, and visitors to use including the fire department, police department, ambulance services, and poison control. This deficient practice could likely result in all 10 (R #s 1, 2,4, 7-13) residents identified on the census provided by the Operations Manager on 10/03/22, to be at risk of harm, injury, or death if there is a delay in receiving emergency medical care and services because there was not a list of emergency numbers posted next to the public	A 031		

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A 031	Continued From page 16 phone. The findings are: A. On 10/03/22 at 10:37 am, during observation of the common area, the facility did not have emergency contact numbers posted near the public telephone. B. On 10/03/22 at 2:01 pm, during an interview with the Operations Manager, she confirmed there were no emergency numbers posted in the facility's common area.	A 031	A031 7 NMAC 8.2.3.1. Handling of Emergencies The Assistant Manager will post a board in the facility's common area to include a list of emergency contact phone numbers for Residents, family and visitors to use including the fire department, police department, ambulance services and poison control. The facility will monitor this daily to ensure ongoing compliance.	12/22/ 2022
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing 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:	A 032		

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A 032	Continued From page 17 (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: REPORTING OF INCIDENTS 7.8.2.32 A. (1) - (2) B. (1) - (3) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W, 8 B. (2), 10 C. W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report	A 032		

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A 032	Continued From page 18 forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. C. All licensed health care facilities shall conduct a complete investigation and report the actions taken and conclusions reached by the facility within five (5) days of discovery of the incident. [7.1.13.10 NMAC - Rp, 7.1.13.11 NMAC, 7/1/14] Based on record review and interview, the facility failed to ensure for 2 (R #4 and 6) of 6 (R #1-6) residents whose Internal Incident Reports (IRs) were reviewed for compliance, that: 1. They were reported to the Licensing Authority within 24 hours or the next business day if it is a weekend or a holiday. 2. The facility conducted and documented the investigation of all reportable incidents within five (5) business days and submit a copy of the investigation report to the Licensing Authority. These deficient practices could potentially result in the residents, to be at risk of harm, injury, and/or death, due to the facility failing to report any "Reportable incident" to the Licensing Authority for oversight. Findings related to R #4 are: A. Record review of R #4's internal incident report	A 032	A. 032 7 NMAC 8.2.32 Reporting of Incidents Continued on next page	12/22/2022

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A 032	Continued From page 19 dated 06/25/22 revealed: 1. [redacted] had an unwitnessed fall and was found on the floor. 2. [redacted] was complaining of pain and was taken to the hospital on 06/26/22 by non-emergency ambulance. B. Record request for an external incident report to the Licensing Authority for the incident on 06/26/22, revealed there was no report made. The findings related to R #6 are: C. Record review of R #6's facility's Internal IRs dated: 1. 06/30/22, revealed R #6 had an unwitnessed fall in [redacted] bathroom. According to the Internal IR, R #6 reported that [redacted] in the bathroom and [redacted] R #6's [redacted] were checked for injuries, in which [redacted] was "walking fine" and was "happy and no pain". The facility's Internal IR does not indicate which [redacted] 2. 08/24/22, revealed R #6 had an unwitnessed fall by the door to [redacted] room. According to the Internal IR, R #6 was found by Direct Care Staff #1 lying on the floor near the entrance of [redacted] room close to the wall and [redacted] walker was not near [redacted] When R #6 was found lying on the floor, [redacted] was "unresponsive for about a minute or two but breathing seemed to be fine. 911 was dialed and we were advised by operator not to move [redacted] unless [redacted] should get [redacted] Upon arrival of the Paramedics at the facility, R #6 was checked, a neck brace was applied, and some bleeding was noted from R #6 [redacted] R #6 was transported to the emergency room (ER) at a local hospital in Santa Fe, NM for further evaluation.	A 032	A. 032 7 NMAC 8.2.32 Reporting of Incidents • • • •• • • • • • • • • • • • The Operations Manager and the Assistant Manager will report to the Licensing Authority, within 24 hours, or the next business day, if it is a weekend or a holiday when there is an IR that meets the criteria established by the DOH. They will ensure this by signing and dating every Incident Report (IR) that is completed by any staff member within the facilities system and reviewing the case to confirm/deny if the IR meets the qualifications for an initiating an external incident report. The facility will monitor the corrective action and ensure ongoing compliance by all Caregivers communicating all IR's immediately to the managers, after the Hospice and or contact person has been notified and vital signs have been recorded. In addition, the facility will conduct a complete internal investigation, report the actions taken and the conclusions reached within five (5) days of the discovery of the incident. The Operations Manager and/or the Assistant Manager will log this information into a binder and review this binder daily. This binder will provide a daily check for any current IR's that are in the discovery mode. This process will monitor the corrective action, with a submitted copy of the IR to the Licensing Authority to ensure ongoing compliance.	12/22/2022

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A 032	Continued From page 20 D. There was no documentary evidence that the facility reported the above incidents for R #4 and 6, to the Licensing Authority within 24 hours or the next business day if a holiday or weekend and that an internal investigation was conducted within 5 business days and submitted a copy of the investigation report to the Licensing Authority. E. On 10/13/22 at 1:37 pm, during an interview with the facility's Operations Manager via a correspondence email, she confirmed that the above facility's Internal IRs were not reported to the Licensing Authority within 24 hours, or the next business day and the facility did not conduct an investigation on the above incidents within 5 business days.	A 032		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate	A 034		

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from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms.
(3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications.
(4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name.
(5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate.
(6) The facility shall not require the residents to purchase medications from any particular 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

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A 034	Continued From page 22 physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]	A 034		

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A 034	Continued From page 23 This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7) Refer to: NFPA (National Fire Prevention Association) 99. 2012 Edition. 11.3 Cylinder and Container Storage Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible 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	A 034		

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shall comply with 5.1.3.3.1.7 with respect to temperature limitations.
11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3.
11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations.
11.3.2.8 Cylinder valve protection caps shall comply with 11.6.2.3.
11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12.
11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2.
11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures.
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

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A 034	Continued From page 25 wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. Based on record review, observation, and interview, the facility failed to ensure that: 1. Oxygen cylinder tanks were stored securely and protected from accidental damage or dislocation. 2. Oxygen cylinder tanks were not stored with combustible materials. 3. Oxygen cylinder tanks were stored no less than 20 ft (6.1 m) from an ignition source. These deficient practices could likely result in the 10 (R #s 1, 2,4, 7-13) residents listed on the resident census, provided by the Administrator 10/03/22, to be at risk of harm, injury, or death if: 1. Oxygen cylinder tanks were to fall over damaging the valve, causing them to depressurize during a fire, the oxygen feeds the fire, causing it to spread faster and/or the cylinder tanks act like missiles and hit a resident/staff/rescuer during a fire. 2. Oxygen cylinder tanks were stored with combustibles (plastic bags and plastic tubing) could accelerate the fire. 3. Oxygen cylinder tanks are stored near a source of combustion and there is a fire. The findings are: A. On 10/03/22 at 10:33 am, during an observation of the facility, 4 unsecured oxygen tanks were observed on the floor of room #14. B. On 10/03/22 at 2:01 pm, during an interview	A 034	A 034 7 NMAC 8.2.34 Custodial Drug Permits Continued on next page	12/22/2022

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A 034	Continued From page 26 with the Operations Manager, she confirmed the findings regarding the 4 unsecured oxygen cylinder tanks on the floor or room #14. C. On 10/04/22 at 10:26 am, during an observation of the facility garage, the following was was found: 1. 21 secured oxygen cylinder tanks were observed to be stored within 15 feet of a fuel-fired water heater/ignition source. 2. Oxygen cylinder tanks were being stored with combustible materials (materials such as wood, paper, and other materials that either burn themselves or add heat to a fire). D. On 10/04/22 at 10:39 am, during an observation of the facility, the following was observed: 1. 2 unsecured oxygen cylinder tanks in the shower of room #8. 2. 3 unsecured oxygen cylinder tanks on the floor in room #9. 3. Oxygen cylinder tanks were stored in the garage near paper and other combustible materials. E. On 10/26/22 at 2:08 pm, during an interview with the Operations Manager, she confirmed: 1. There were 2 unsecured oxygen cylinder tanks in the shower of room #8. 2. 3 unsecured oxygen cylinder tanks on the floor in room #9. 3. 21 secured oxygen cylinder tanks were being stored within 15 feet of a fuel-fired water heater/ignition source.	A 034	A 034 7 NMAC 8.2.34 Custodial Drug Permits Continued These violations, identified in the official statement of deficiencies, will be corrected by The Operations Manager and the Assistant Manager. They will verify that every oxygen cylinder, arriving into the facility, will be checked through the front office first, before their destination into the Resident's quarters. There will be a binder in the office, identifying the name of the medical company and the amount of oxygen cylinders provided to which Resident, with a date and signature from an employee that receives this medical equipment. This monitoring of receiving oxygen cylinders will provide the corrective action to ensure ongoing compliance by confirming that the oxygen cylinders are stored appropriately, per the National Fired Prevention Association (NFPA) Regulations.	12/22/2022
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned	A 036		

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A 036	Continued From page 27 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 (3) meals or their equivalent each day at regular times with no more than sixteen (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 (1) week cycle; (e) have special menus or meal items following 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	A 036		

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A 036	Continued From page 28 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 forty-eight (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 thirty (30) 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 036		

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A 036	Continued From page 29 (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. (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	A 036		

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A 036	Continued From page 30 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, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) 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 (3) 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 thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) 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 (3) 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. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be	A 036		

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A 036	Continued From page 31	A 036		

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 pursuant to Subsection B of 7.6.2.8 NMAC.
(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 (6) 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 forty-one (41) degrees fahrenheit;
(b) the temperature for all hot foods is maintained at one hundred forty (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 regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having

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A 036	Continued From page 32 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. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 C (1) (a) D (3) Based on observation, and interview, the facility failed to ensure, that: 1. Kitchen equipment and work areas were clean and in good repair. 2. Food stored in refrigerators and freezers were covered, dated, and labeled and any unused leftover foods were discarded after three (3) calendar days. 3. Expired food stored in refrigerators was discarded. These deficient practices could likely result in the 10 (R #s 1, 2,4, 7-13) residents listed on the census provided by the House Manager on 10/03/22, to be at risk of contracting foodborne illnesses, harm or death if: 1. Kitchen and equipment where food is prepared are not kept clean and sanitary. 2. The food, was not stored properly (dated, labeled), and leftovers were kept longer than (3) three days, after being served the 1st time. 3. Expired food becomes contaminated with bacteria and germs and could cause harm or death to residents. The findings are:	A 036		

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A 036	Continued From page 33 A. On 10/04/22 at 10:20 am, during an observation of the kitchen, the following was observed: 1. The cabinet floorboard underneath the sink was observed to be rotting and in ill repair. 2. The floor drain underneath the sink was observed to contain food residue buildup. 3. One (1) expired bottle of orange juice dated 09/09/22. 4. One (1) container of salsa that was not labeled or dated. B. On 10/05/22 at 10:01 am, during an interview, the House Manager she confirmed that the: 1. Cabinet floorboard underneath the sink was rotting and in ill repair. 2. Floor drain underneath the sink contained food residue buildup. 3. Food items in the refrigerator were expired; not labeled, or dated.	A 036	A 036 7 NMAC 8.2.36 Nutrition These violations identified in the official statement of deficiencies will be corrected by The Operations Manager and/or the Assistant Manager by contacting the facilities maintenance technician to replace the cabinet floorboard underneath the kitchen sink, and clean the floor drain from food residue buildup. The facilities cook will check on the floor drain daily, by his/her signature and date documented in a binder. The food items in the refrigerator will be monitored daily for any expired or unlabeled food, by the facility's cook, with his/her signature and date documented in a binder. All employees will be required to sign a document understanding the responsibility to adhere to this policy.	12/22/ 2022
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the	A 037	These actions will ensure that the facility complies with the regulations, confirming ongoing compliance.	

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A 037	Continued From page 34 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 alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (10) Based on observation and interview the facility	A 037		

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A 037	Continued From page 35 failed to ensure that the laundry/cleaning supplies were kept in a secured room, closet, or cabinet. This deficient practice could likely result in the 10 (R #s 1, 2,4, 7-13) residents identified on the census provided by the Operations Manager on 10/03/22, to be at risk of harm or injury if they were to ingest or spill laundry or cleaning supplies on their face or body. The findings are: A. On 10/03/22 at 10:25 am, during observation of the unlocked facility laundry room, the following laundry and cleaning supplies were observed to be unsecured and accessible to residents: 1. (1) one, 2.37 gallon bottle of multipurpose cleaner 2. (1) one, 32 ounce toilet bowl cleaner 3. (1) one, 9.7 ounce multisurface cleaner 4. (3) three, 1 quart bottles glass cleaner 5. (4) four, 15.5 ounce cans disinfectant spray 6. (6) six, 14.6 ounce can disinfectant air freshener 7. (1) one, 1 gallon all purpose cleaner 8. (1) one, 25 ounce bathroom cleaner 9. (1) one, 1 gallon odor remover. 10. (1) one, 19 ounce carpet cleaner 11. (1) one, 2.64 quart odor eliminator concentrate 12. (1) one, 1.56 gallon laundry detergent 13. (1) one, 1 gallon liquid bleach 14. (1) one, 124 ounce paint 15. (1) one, 10.1 ounce silicone sealant 16. (1) one, 30 count leather conditioning wipes 17. (1) one, 1 quart shower, tub & tile cleaner 18. (3) three, 19 ounce foaming glass cleaner B. On 10/03/22 at 2:01 pm, during an interview with the Operations Manager, she confirmed that the above listed laundry and cleaning supplies	A 037	A 037 7 NMAC 8.2.37 Laundry Services All of the facilities employees will sign and date a document to be created by the Assistant Manager, to confirm their responsibility, in maintaining a locked laundry room, when not in use. The facility will monitor the corrective action throughout the day to ensure ongoing compliance, by confirming that the laundry door is always locked when not in use.	12/22/ 2022

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A 037	Continued From page 36 were stored in the unlocked laundry room, unsecured, and accessible to residents.	A 037		
A 038	7 NMAC 8.2.38 Housekeeping Services 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 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. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 C Based on observation and interview, the facility failed to ensure that "Poisonous or flammable substances" were not stored in residential areas	A 038		

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	2179	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
BEE HIVE HOMES OF SANTA FE	3838 THOMAS ROAD SANTA FE, NM 87507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 038	Continued From page 37 or in food preparation or storage areas and kept in a secured room or cabinet. These deficient practices could potentially result in the 10 (R #s 1, 2,4, 7-13) residents listed on the resident census list provided by the Operations Manager on 10/03/22, to be at risk of harm, injury, or death if, the facility does not secure "Poisonous or flammable substances" from residents accessing them, there is a potential for ingesting chemicals, inhaling fumes, or being exposed to chemicals spills. The findings are: A. On 10/04/22 at 10:20 am during observation of the facility's kitchen, both of the kitchen doors were not locked (one door accessible from the residents dining area and the other door from the resident's Westside hallway), the following chemicals were found. 1. One (1), 32 ounce of bleach cleaner 2. Two (2), 9.7 ounce of multisurface cleaner 3. One (1), 1 gallon of bleach 4. One (1), can of stainless-steel cleaner 5. Three (3), bottles of oven cleaner 6. One (1), 1 gallon degreaser 7. One (1), 12 ounce insect killer B. On 10/05/22 at 10:01 am, during an interview with the Operations Manager, she confirmed the findings above.	A 038	A 038 7 NMAC 8.2.38 Housekeeping Services The facility will correct these violations by requiring all employees to sign and date a document to be created by the Assistant Manager, to confirm their responsibility, in maintaining each of the two kitchen doors to be locked, at all times, and to only store chemicals in the locked laundry room11/23/2022. The facility will monitor the corrective action throughout the day to ensure ongoing compliance, by confirming that these kitchen doors remain locked.	12/22/ 2022