Fax Cover Sheet

To NMDOH Review Office From Shonna Lawson
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RE POC Date 8-7-23

Notes:

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Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2083	A. BUILDING: ______ B. WING ______	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF ALAMOGORDO	1106 SAN CRISTO ALAMOGORDO, NM 88310

(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
{A 000}	Initial Comments The following deficiency was cited during a Revisit complaint survey completed on 07/13/23, for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities for Adults. Census: 13 DEFINITIONS/ACRONYMS/ABBREVIATIONS: aka: also known as ALF: Assisted Living Facility APS: Adult Protective Services CT Scan: Computed Tomography scan CVA: CerebroVascular Accident - aka stroke DCS: Direct Care Staff EMS: Emergency Medical Service en route: On the way ER: Emergency Room HM: House Manager LA: Licensing Authority LPN: Licensed Practical Nurse POA: Power of Attorney R: Resident RN: Registered Nurse Stroke: CerebroVascular Accident (CVA) TV: Television UTI: Urinary Tract Infection	{A 000}	Beehive staff will schedule an Inservice with the NMDOH Intake Coordinator on incident reporting. All incidents will be reported in the time frame indicated by NMAC 8.2.32 within 24 hours or the next business day if the incident happens on a weekend or holiday. A follow-up internal investigation and 5 day follow up will be submitted timely. Administrator will be notified immediately of a reportable incident. Reportable incidents will be monitored for completion by administrator or designee within 5 days of initial report.	8-31-23
{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	{A 032}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 8-2-23 07/28/23

8-2-23

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{A 032}	Continued From page 1 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: (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: 1 7.8.2.32 A (1-2) B (1- 3) 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	{A 032}		

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{A 032}	Continued From page 2 order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. 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. Based on record review and interview, the facility failed to ensure for 5 (R #2, R #3, R #4, R #5, and R #6) of 6 (R #2, R #3, R #4, R #5, R #6, and R #7) residents whose Internal Incident Reports were reviewed for compliance that the facility: 1. Reported all suspected cases or known incidents of resident abuse, neglect, or exploitation or incident of unusual occurrence which has or could affect the health, safety, or welfare of the residents and staff to the Licensing Authority within twenty-four (24) hours or by the	{A 032}		

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	2063	A. BUILDING: ______ B. WING ______	R-C 07/13/2023

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{A 032}	Continued From page 3 next business day, if it is a weekend or a holiday. 2. Conducted an internal investigation of the incidents. 3. Submitted a follow-up investigation report to the Licensing Authority within five (5) business days from the date the incident occurred. These deficient practices could likely result in the residents to be at risk of harm, injury, and/or death, if incidents occur and there is no oversight by the Licensing Authority. The findings are: Resident #2: A. Record review of R #2's Internal Incident Reports revealed that: 1. On 06/05/23 at 9:37 am, when DCS #1 attempted to block R #2 from leaving the facility, while another family was returning their loved one: a) R #2 threatened to hit DCS #1 if she stopped him from leaving. b) DCS #1 stepped aside, to avoid injury, and allowed R #2 to leave the facility and cross the street. c) DCS #1 was unsuccessful in convincing R #2 to return to the facility. d) Eventually, the facility's maintenance man was able to convince R #2 to return to the facility o[redacted] own. 2. On 06/22/23 at 9:10 am, when an DCS (unknown) entered R #2's room, the report completed by DCS #3 stated that: a) Evidence of an attempted elopement had occurred the night before [redacted] bed had been moved to the window and curtain rod was down and bent). b) It was unknown when the last time the resident was checked on and noted that the	{A 032}		

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{A 032}	Continued From page 4 resident stated [redacted] B. Record review of R #2's behavioral health clinic physician progress notes, dated 06/22/23 revealed: 1. Reason for admission: "Danger to self, and danger to others." 2. Discharge diagnoses: [redacted] 3. Discharged back to facility on [redacted]/23. C. Record review of R #2's resident file revealed the following shift-change notes: 1. On 06/22/23 at 10:24 pm, DCS noted that R #2 was under care of emergency services since 4:30 pm and is out at hospital/absent. 2. From 06/23/23 to 06/28/23, R #2 in hospital. 3. On 06/28/23 at 9:52 pm, R #2 returned to [redacted] 4. On 06/29/23 at 8:50 pm, R #2 was confused and talking to the TV. 5. On 06/29/23 at 10:28 pm, loud laughter came from R #2's room and when DCS entered R #2's room to see what was happening, she found [redacted] to be talking to somebody who was not present. 6. On 06/30/23 at 1:41 pm. R #2 was still confused/hallucinating. D. On 07/12/23 at 4:05 pm, during an interview with the Administrator, she confirmed that: 1. On 06/05/23 at 9:37 am, R #2 threatened to hurt DCS #1 when she tried to block [redacted] from leaving the facility and [redacted] was allowed to exit the facility, even walking across the street until the facility's maintenance man convinced [redacted] to	{A 032}		

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{A 032}	Continued From page 5 return. 2. On 06/22/23 at 9:10 am, a DCS discovered evidence that R #2 had attempted to [redacted] the prior evening and she noted that [redacted] had previously stated to her that [redacted] would [redacted] 3. R #2 had behavioral issues, and [redacted] was eventually sent to the behavioral hospital. 4. The facility failed to file incident reports for the 06/05/23 or 06/22/23 incidents concerning R #2's threat of injuries to staff and injuries/suicidal threats to [redacted] with the Licensing Authority. 5. The facility failed to conduct an internal investigation of the above incidents and/or submit investigation follow-up reports to the Licensing Authority within (5) five business days from the date the incidents occurred. Resident #3: E. Record review of R #3's Internal Incident Reports revealed: 1. On 05/23/23 at 1:11 am, an unwitnessed fall occurred. a) DCS ran to R #3's room when [redacted] yelled for help and she found R #3 on the floor between [redacted] bed and the wall. b) The DCS determined that [redacted] while attempting to retrieve [redacted] c) R #3 had a small cut on [redacted] d) DCS called 911 and when the ambulance arrived, R #3 told EMS that he did not want to go to the hospital. e) Administrator notified R #3's [redacted] POA of the incident. 2. On 06/22/23 at 5:30 pm, the following incident occurred: a) DCS found R #3 in [redacted] room; bent over and leaning to the side in [redacted] wheelchair. b) DCS called R #3's name but [redacted] response	{A 032}		

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{A 032}	Continued From page 6 was confused, and vitals were taken. c) DCS called 911. d) While awaiting ambulance, R #3 began to shake and lean to [redacted] was not responding to their voices, nor would [redacted] look at them. e) Ambulance arrived and transported R #3 to the hospital ER. F. On 07/12/23 at 4:05 pm, during an interview with the Administrator, she confirmed that: 1. On 05/23/23 at 1:11 am, R #3 had an unwitnessed fall, and [redacted] was found on the floor between [redacted] bed and the wall. a) R #3 had a small cut on [redacted] b) EMS was called, but R #3 refused to go to the hospital. 2. On 06/22/23 at 5:30 pm, R #3 was found slumped to the side while in [redacted] wheelchair and [redacted] was taken by ambulance to the ER. a) The incident was an unusual occurrence. b) The doctor diagnosed R #3 with a severe UTI. 3. There was no additional documentation available in R #3's file containing documentation of the DCS observing R #3's right forearm or the UTI treatment/outcome. 4. The facility failed to file Incident Reports with the Licensing Authority concerning the 05/23/23 unwitnessed fall, injury/condition of unknown injury/condition, and the 06/22/23 transport to the hospital with an unusual occurrence of injury/condition of unknown origin. 5. The facility failed to conduct an internal investigation of the incident and/or submit an investigation follow-up report to the Licensing Authority within (5) five business days from the date the incidents occurred. Resident #4:	{A 032}		

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{A 032}	Continued From page 7 G. Record review of R #4's Internal Incident Reports revealed that: 1. On 03/28/23 at 11:45 am, R #4 was seen losing [redacted] balance while walking to the bathroom and [redacted] backwards into [redacted] 2. DCS assessed him for injury, and [redacted] was able to move all extremities freely. 3. DCS noted a knot on the back of R #4's head, [redacted] had a [redacted] and R #4 stated that [redacted] 4. Hospice nurse assessed the resident and nothing remarkable was noted. H. On 07/12/23 at 4:05 pm, during an interview with the Administrator, she confirmed that: 1. R #4 was witnessed falling backward into [redacted] wall, [redacted] 2. She looked through hospice nurse notes and was unable to find any documentation of the hospice nurse's assessment of R #4 after the fall. 3. The facility had no progress notes available regarding the incident. 4. The facility failed to file an incident report concerning R #4's head injury, rug burn, and [redacted] 5. The facility failed to conduct an internal investigation of the incident and/or submit an investigation follow-up report to the Licensing Authority within (5) five business days from the date the incident occurred. Resident #5: I. Record review of R #5's Internal Incident Reports revealed that: 1. On 02/21/23 at 10:22 am, other residents witnessed R #5 fall backward, out of [redacted] dining room chair. 2. Staff did not witness the fall, but found [redacted] on the floor, [redacted] and they discovered that [redacted] on the floor.	{A 032}		

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{A 032}	Continued From page 8 3. DCS took vitals and felt a [redacted] 4. R #5 had a regular doctor appointment scheduled that day and [redacted] took [redacted] to be evaluated. J. On 07/12/23 at 4:05 pm, during an interview with the Administrator she confirmed that: 1. Other residents witnessed R #5 falling out of [redacted] dining room chair, but the fall was unwitnessed by staff. 2. R #5 had [redacted] when [redacted] fell backward onto the dining room floor. 3. Staff determined that [redacted] when they felt a bump on the [redacted] 4. R #5's [redacted] took [redacted] to a regular-scheduled appointment afterward and the daughter said the doctor said that [redacted] was fine. 5. There are no progress notes or doctors notes available in R #5's file regarding the head injury and/or the doctor appointment. 6. The facility failed to file an Incident Report with the Licensing Authority concerning the unusual occurrence of injury/condition of unknown origin. 7. The facility failed to conduct an internal investigation of the incident and/or submit an investigation follow-up report to the Licensing Authority within (5) five business days from the date the incidents occurred. Resident #6: K. Record review of R #6's Internal Incident Reports revealed that: 1. On 06/07/23 at 2:33 am, R #6 had an unwitnessed fall. 2. DCS heard a loud bang and ran into R #6's room, where he was found lying on the floor. 3. R #6 stated that he had fallen and DCS noted tha[redacted]	{A 032}		

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{A 032}	Continued From page 9 4. R #6 frequently gets up without help, and due to a previous head injury, the Administrator called the ambulance and the resident was taken to the hospital for further evaluation. L. Record review of R #6's Emergency Services Report dated 06/07/23, revealed that R #6: 1. Had been taken to the hospital for a fall. 2. Was discharged from the ER to return back to the facility. 3. Was secured onto a stretcher with belts and rails for safe transport back to the facility and R #6 had stated [redacted] was still hurting en route back to the facility. 4. Discharge paperwork stated that R #6 had sprained [redacted] 5. Impression/Reason for transport stated that R #6 was unable to safely sit upright during transport. 6. Primary symptom was weakness and medical history stated [redacted] M. On 07/12/23 at 4:05 pm, during an interview with the Administrator, she confirmed that: 1. R #6 had an unwitnessed fall. 2. DCS found R #6 lying on the floor and R #6 stated that [redacted] had fallen. 3. DCS noted that R #6 had [redacted] 4. She called the ambulance, and R #6 was taken to the hospital for further evaluation. 5. The hospital did a CT scan and there was no injury, per the ER doctor. 6. The facility did not have any progress notes to confirm the outcome or the doctor's diagnosis. 7. The facility failed to file an Incident Report with the Licensing Authority concerning the unusual occurrence of injury/condition of unknown origin. 8. The facility failed to conduct an internal	{A 032}		

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{A 032}	Continued From page 10 investigation of the incident and/or submit an investigation follow-up report to the Licensing Authority within (5) five business days from the date the incidents occurred.	{A 032}		