Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2045	A. BUILDING: _____ B. WING _____	C 01/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF RIO RANCHO I	204 SILENT SPRING ROAD RIO RANCHO, NM 87124

(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 A survey was completed for NMAC 7.8.2 regulations governing Assisted Living facilities for intake 28803. The complaint was substantiated with deficiencies cited.	A 000	A-033 In the future, if Beehive Homes Suspects an Injury of a Patient recieving Hospice or Home Health services and if We feel that Hospice or Home Health has not thoroughly treated the patient/Resident, Beehive Homes will request further treatment from Hospice/Homehealth or Send Resident to recieve Emergency Services. Beehive Homes did report residents incidents	
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall:	A 033	Scanned 04-02-13 JC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3-25-2013

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A 033	Continued From page 1 (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room;	A 033	A-033 and Pain to the Medical Staff of hospice. The resident was seen for the Pain in her leg on Several Occasions. These visits were Prompted by Beehive Homes as is our Policy When we See anything that Should be brought to the attention of Medical professionals. These Changes will be made as of 3.25.2013	
	(9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written			

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A 033	Continued From page 2 notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan.	A 033		

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A 033	Continued From page 3 [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to protect the resident's right to receive prompt medical attention for one (Resident #1) of 15 (#2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15) facility residents. This has the potential to negatively impact all facility residents who experience an accident or injury. The findings are: A. Facility incident report dated 09/16/12 at approximately 1:00 pm and reads that Caregiver #1 and Caregiver #2 found Resident #1 by the front door on the floor. Subsequent to the fall, Resident #1 complained of pain in the left arm. B. Facility incident report dated 10/18/12 reads that during a transfer from wheelchair to bed on that day, Resident #1's legs gave out and she slid slowly to the floor. The resident resulted with a skin tear from the incident as documented by Caregiver #1. C. Internal investigation documentation dated 11/20/12 by the facility Administrator documents that about a week after Resident #1's [sic] fell, she began complaining of pain in her right thigh, knee and foot. Resident #1's pain was very well documented and was reported to hospice. Resident #1 was seen by the hospice nurse on several occasions and the hospice nurse was very aware of the pain that Resident #1 was experiencing. Hospice treated Resident #1 pain with pain killers but remarked on 12/13/12 at 1:27 pm that he did not know why further action was	A 033		

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A 033	Continued From page 4 not taken regarding Resident #1's leg. D. Interview with Caregiver #2 on 11/28/12 at 4:09 pm revealed that on 09/15/12 Resident #1 had been confused and speaking of going home. At around 1:00 pm Caregivers #1 and Caregiver #2 heard something and found that Resident #1 was in the doorway of the home. Caregiver #2 reported that Caregivers #1 and Caregiver #2 "assessed" Resident #1 who complained of left arm pain. The physician was notified and an x-ray was apparently ordered for the arm. However, the physician did not come to do an assessment at that time. On 11/02/12 at 5:00 pm, Caregiver #2 recalled that the facility received a call from the Hospice nursing agency serving Resident #1 and the nurse told the staff "not to move" the resident. Caregiver #2 reported that it had been discovered that Resident #1's leg was broken in the course of daily care of Resident #1. Caregiver #2 placed the call to Emergency Medical Services and spoke to them when they arrived. She reported that she "had heard" that Resident #1 was involved in an incident a week prior in which she could not bear weight during a transfer. She reported not knowing who was involved but reported that it "wasn't her". E. Interview with Caregiver #1 on 12/06/12 at 3:29 pm revealed that she has been a caregiver at the facility for 6 months and is a Medical Technician by trade. Caregiver #1 reports that on 10/18/12 she was transferring Resident #1 independently from her wheelchair to her bed. Caregiver #1 reported that up to that time Resident #1 was a 1-person transfer but on that day Caregiver #1 noticed that Resident #1 condition changed when Resident #1 was unable to assist with the transfer. Caregiver #1	A 033		

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A 033	Continued From page 5 attempted the transfer when Resident #1 could not help with the transfer as previous. Upon this discovery, Resident #1 slid to the floor during the attempt to transfer. Following that Caregiver #1 called Caregiver #2 for assistance. Caregiver #1 reported that they picked Resident #1 up and into her bed, bandaged the skin tear and wrote an incident report. Caregiver #1 reports that Resident #1 did not verbalize pain following the incident but reports that prior to that incident Resident #1 reported pain in her leg and would point to her leg. Caregiver #1 reports that she does not think that Resident #1 was seen by any medical personnel. F. Interview with Caregiver #3, caregiver of more than 25 years, on 11/20/12 at around 1:00 pm reports that Resident #1 would point to her leg and say the word "pain". Caregiver #3 says that she reported this to the hospice agency nurse various times but did not state exact dates during interview. Caregiver #3 reports that she was told that it was "arthritis" by the hospice nurse even when she pointed out the contorted position in which Resident #1's leg was found. Caregiver #3 reports that Resident #1 was not seen by the hospice physician until the pictures of her leg were sent via picture mail over the phone. Only then were x-rays ordered by hospice for Resident #1's leg. G. Interview with the daughter of Resident #1 at 9:35 am revealed that on 09/15/12 a phone call regarding a fall involving Resident #1 was received Interviewee #1 was told that it was a fall out of the wheelchair near the front door and that (Resident #1) seemed to be okay. Interviewee #1 was not informed of any medical attention received by Resident #1 at the time of the fall. Interviewee #1 reports that shortly after that time,	A 033		

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A 033	Continued From page 6 Resident #1 began to receive services from a hospice nursing agency. Interviewee #1 reports that she did not know the particulars of assessments and activities of daily living (ADLs) but remembers that Resident #1 ate some meals out of bed. Interviewee #1 recalls that Resident #1 wanted to be bed bound more after that time because of "pain" as reported to her by staff of the facility. Interviewee #1 reports that she noticed on 10/14/12 that Resident #1's leg was swollen and was verbalizing excruciating pain in her leg. "I (Interviewee #1) saw her moan and groan and rub her leg". She reports seeing a boil on Resident #1's leg on a 10/31/12 facility visit and noting that it was the size of a ping pong ball and purple in color. Finally, Resident #1's daughter reports that the facility had only informed her of one fall incident involving Resident #1 on 09/15/12. H. Review of hospice documentation revealed that nursing care admission was on 09/23/12. Initial intake dated 09/23/12 reads that Resident #1 "has shown decline in last 2-3 weeks [sic] recent fall." Prognosis Determination form dated 09/23/12 reads that the patient (Resident #1) "has shown decline in the last 3 weeks [sic]; had a recent fall with suspected injury [sic]; mild to moderate cognitive impairment and she is dependent for all ADL's". Hospice Nursing Assessment narrative dated 10/05/12 read that the resident "would slightly grimace and moan then return to sleep". However, under page 1 of the nursing assessment under the "pain" heading is documented "pt (patient) denies". Further, on hospice nursing assessment dated 10/09/12 , the nurse documented under the heading "pain" - "lots of pain all over". Similarly, on hospice nursing assessment dated 10/12/12 under the heading "pain", the nurse documents that patient	A 033		

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A 033	Continued From page 7 "grimacing and moaning and holding 'R' (right) thigh". The narrative on the same assessment dated 10/12/12 documents that the nurse observed a transfer at the facility in which the patient "was moaning and crying out and holding 'L' (left) thigh. Staff said [patient] told them that she could not move her leg. Instructed staff to provide pain med [medication]." Nursing assessment dated 10/24/12 documents that patient "right knee swollen, pt [patient] grimaces [sic] moans when Rt. [right] LE [lower extremity] is moved." The narrative report reads that the nurse "observed facial grimace and moaning when R [right] leg is moved." Nursing assessment dated 10/26/12 documents under "pain" that "pt [patient] denies" and documents in the narrative that patient "unable to report accurately [sic] pain and other symptoms. Facility reports no change in patient condition since last RN [nurse] visit". On nursing assessment dated 10/29/12 under the heading "pain", is documented "pt [patient] denies". I. Review of incident report submitted by the facility on 11/3/12 re-iterates that Resident #1 fell on 09/15/12 and received an x-ray on her arm which revealed no injury. However, it notes that the resident did complain of leg pain at that time. On 11/02/12 at 5:00 pm a sore that became a boil erupted revealed an exposed bone. Upon this discovery, the hospice nursing agency was contacted and Emergency Medical Services was contacted for transport of the Resident #1 to the hospital. J. Review of Emergency Medical Services (EMS) Narrative reveals that on 11/02/12 Resident #1 appeared to be alert and oriented to inform EMS of leg pain and pointing to her right leg. The report reads that that facility staff	A 033		

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A 033	Continued From page 8 reported to EMS that Resident #1 was dropped one week earlier. An x-ray conducted on site that afternoon had revealed a break in the right femoral bone above the knee. Examination of the injury revealed an open femoral fracture on the right leg with a large amount of discharge noted. Resident #1 was transported to the hospital by Emergency Medical Services. K. Review of hospital history and physical dated 11/03/12, revealed that Resident #1 was admitted to the hospital with a compound fracture of her right femur. Report reads that on 09/15/12 Resident #1 fell from her wheelchair and her general condition has deteriorated since that time. In addition, three weeks prior, Resident #1 was noted to have swelling of the right eye and a sore above her right knee. Assessment revealed that Resident #1 sustained a right compound femoral fracture with open femoral fragment protruding approximately two (2) centimeters through the skin. Assessment revealed unclear date of occurrence but indicates that perhaps as long ago as approximately six weeks or sometime in the last 3 weeks, when Resident #1's leg began to exhibit signs of swelling. Resident #1 passed away on 11/17/12.	A 033		