STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2141	A. BUILDING: _____ B. WING _____	C 09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF SAN PEDRO, BUILDING C	6401 CORONA NE ALBUQUERQUE, NM 87113

(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 deficiencies were cited as a result of a Full-Onsite/Complaint survey completed on 09/17/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint intake NM#37724 was unsubstantiated with no deficiencies cited related to the complaint.	A 000		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC;	A 020		

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A 020	Continued From page 1 (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require	A 020		

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A 020	Continued From page 2 continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in	A 020		

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A 020	Continued From page 3	A 020		

writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall:
(a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met;
(b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES);
(c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and
(d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility.
(3) The team recommendation shall be maintained on site in the resident ' s file.
(4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident.
D. Coordination of care.
(1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers.
(2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider.
[7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]

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A 020	Continued From page 4 This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude	A 020	A 020 FACILITY SHALL UPDATE ALL RESIDENT FILES TO INLCUDE A REFUND POLICY IN COMPLIANCE WITH NMAC 7.8.2.20 and (SB) 0335 - 2013.	11/30/2019

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A 020	Continued From page 5	A 020		

renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them.

C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health."

SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

Based on record review and interview the facility failed to ensure for 1 (R #1) of 4 (R #s 1-4) residents whose admission/discharge agreements were reviewed for compliance that it included a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. This deficient practice has the potential for all residents to be at risk of not receiving a refund of monies owed from the facility or being aware of potential additional charges that can occur. The findings are:

A. Record review of R #1's admission/discharge agreement date[redacted]14 revealed no documentation of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013.

B. On 09/18/2019 at 2:00 pm, during an interview with the Administrator, she confirmed that R #1's admission/discharge agreement did not include a refund upon death policy that was in compliance

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A 020	Continued From page 6 with NMAC 7.8.2.20 and (SB) 0335 - 2013.	A 020		
A 023	7 NMAC 8.2.23 Pets PETS: Pets are permitted in a licensed facility, in accordance with the facility's rules. A. Prohibited areas. Animals are not permitted in food processing, preparation, storage, display and serving areas, or in equipment or utensil washing areas. Guide dogs for the blind and deaf and service animals for the handicapped shall be permitted in dining areas pursuant to Subsection K of 7.6.2.9 NMAC. B. Vaccination. Pets shall be vaccinated in accordance with all state and local requirements and records of such vaccination shall be kept on file in the facility. [7.8.2.23 NMAC - Rp, 7.8.2.24 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.23 B Based on record review, observation and interview, the facility has failed to maintain proper documentation that the pets who live in the facility had been vaccinated as needed. The deficient practice has the potential for all 13 (R #s 1-13) residents identified on the census provided by the House Manager on 09/17/19, to be at risk of contracting communicable diseases through direct/indirect contact with the pets, become ill, and need medical treatment if the pets were not up to date on their vaccinations. The findings are: A. On 09/18/19 at 9:50 am, during observation it was observed that the facility had 2 pet birds in a	A 023	A 023 FACILITY SHALL MAINTAIN PROPER VACCINATIONS DOCUMENTATION FOR PETS LIVING IN THE FACILITY.	12-15-19

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A 023	Continued From page 7 cage in the common area. B. Record request for the current vaccination records for the 2 birds living at the facility revealed no documentation that the birds had been vaccinated. C. On 09/18/2019 at 9:54 am, during interview, the Administrator confirmed that the facility did not have vaccination records for the birds.	A 023		
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 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.	A 031		

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A 031	Continued From page 8 [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 C Based on observation and interview, the facility failed to ensure that there was a public phone available in the facility for calling for help in case of an emergency. This deficient practice has the potential for all 13 (R #s 1-13) residents identified on the census provided by the House Manager on 09/17/19, to be at risk of harm, injury, or death due to a delay in emergency services if there is no public telephone available. The findings are: A. On 09/18/19 at 9:57 am, during observation of the common areas of the facility, no telephone was observed to be available for use by residents/family/visitors/staff. B. On 09/18/19 at 9:58 am, during an interview with the House Manager, she confirmed that there was no public telephone available for use by residents/family/visitors/staff in the facility.	A 031	A 031 FACILITY SHALL MAKE A PHONE AVAILABLE IN THE PUBLIC AREA FOR ALL RESIDENTS AND VISITORS TO USE IN CASE OF EMERGENCIES.	12-15-19
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	A 034		

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A 034	Continued From page 9 shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular 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	A 034		

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A 034	Continued From page 10 (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be 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	A 034		

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A 034	Continued From page 11 of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (9) Based on record review and observation the facility failed to remove discontinued medication from the medication cart to a separate locked storage container for destruction by the consulting pharmacist. This deficient practice has the potential for all 13 (R #s 1-13) residents identified on the census provided by the House Manager on 09/17/19, to be at risk of illness, harm, or death if discontinued medications are taken in error. The findings are: A. On 09/17/19 at 2:27 pm, during observation of the facility medication cart the following discontinued medications were observed to still be in the cart with R #3s current medications: [redacted]	A 034	A 034 FACILITY SHALL REMOVE ALL DISCONTINUED MEDICATIONS FROM MEDICATION CART TO A SEPARATE LOCKED STORAGE CONTAINER TO AWAIT DESTRUCTION BY THE CONSULTING PHARMACIST.	9/30/19

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A 034	Continued From page 12 B. On 09/17/19 at 3:30 pm, during an interview, the House Manager confirmed that the medications for R #3 listed above had not been removed from the medication cart when discontinued.	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the	A 035		

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(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 035	Continued From page 13 circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug	A 035		

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	2141	A. BUILDING: _____ B. WING _____	C 09/18/2019

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A 035	Continued From page 14 product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged.	A 035		

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A 035	Continued From page 15 Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (4) (5) (12) (13) Based on record review and interview the facility failed to ensure for 4 (R #s 1-4) of 4 (R #s 1-4) residents whose Medication Administration Records (MARs) were reviewed for compliance that they were complete, accurate, and included all required information. These deficient	A 035		

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A 035	Continued From page 16 practices have the potential to negatively affect the health, safety, and welfare of all 13 (R #s 1-13) residents identified on the census provided by the House Manager on 09/17/19, if the information on the MAR is not accurate, complete, included all required information and medication errors occurred. The findings are: A. Record review of R #1's 09/01/19 to 09/18/19 MAR revealed the following information was missing: [redacted]	A 035	A 035 ALL RESIDENT MAR'S HAVE BEEN UPDATED TO INLCUDE: 1- DIAGNISIS/REASON 2-BOTH BRAND AND GENERIC NAME OF MEDICATION 3- STRENGTH/DOSAGE ALL DISCONTINUED MEDICATIONS HAVE BEEN REMOVED FROM THE MEDICATION CART. ALL MEDICATIONS THAT ARE LISTED ON THE MAR ARE AVAILBLE IN THE MEDICATION CART.	9/30/19

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A 035	Continued From page 17	A 035		

[redacted]

4. Medications listed on the MAR that were not available in the medication cart.

[redacted]

B. Record review of R #2's 09/01/19 to 09/18/19 MAR revealed the following information was missing:

[redacted]

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A 035	Continued From page 18	A 035		

[redacted]

3. No documentation of the medication strength was documented for Latanoprost/Xalatan - Glaucoma.

C. Record review of R #3's 09/01/19 to 09/18/19 MAR revealed the following information was missing:

[redacted]

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A 035	Continued From page 19 [redacted] D. Record review of R #4's 09/01/19 to 09/30/19 MAR revealed the following Missing information: [redacted]	A 035		

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A 035	Continued From page 20 3. Medications listed on the MAR that were not available in the medication cart. [redacted] E. On 09/17/19 at 3:30 pm, during an interview with House Manager, she confirmed the above findings for R #s 1-4's 09/01/19-09/30/19 MARs.	A 035		
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 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.	A 037		

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A 037	Continued From page 21 (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 failed to ensure that laundry and cleaning supplies were kept in a secured room, closet, or cabinet. This deficient practice has the potential for all 13 (R #s 1-13) residents identified on the census provided by the House Manger on 09/17/19, 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 09/17/19 at 8:44 am, during an observation of the unlocked laundry room, the following laundry and cleaning supplies were observed to be accessible to residents, some with	A 037	A 037 LAUNDRY AND CLEANING SUPPLIES ARE NOW BEING KEPT IN A SECURE ROOM. A CODED DOOR LOCK HAS BEEN ADDED TO THE LAUNDRY ROOM DOOR.	9/30/19

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A 037	Continued From page 22 dementia-memory loss. 1. (1) 1-gallon container of liquid deodorizer 2. (1) 1-gallon container of pink hand soap 3. (3) 10 oz cans of air deodorizer 4. (1) 32 oz container of stain remover 5. (1) 32 oz container of glass cleaner 6. (1) 6 oz container of disinfectant 7. (1) 16 oz bottle of hydrogen peroxide B. On 09/17/19 at 10:15 am, during an interview with the House Manager, she confirmed that the above listed laundry and cleaning supplies were in the unlocked laundry room and accessible to residents, some with dementia-memory loss.	A 037		
A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or (3) other hazardous areas shall be enclosed with	A 043		

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A 043	Continued From page 23 walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.43 Reference NFPA 99, 1999 Edition Section 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous	A 043		

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A 043	Continued From page 24 oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7]. 6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. 7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.	A 043		

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A 043	Continued From page 25 9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)]. Based on observation and interview, the facility failed to ensure that oxygen cylinder tanks and combustible items including cardboard boxes, holiday decorations, discarded household items, and durable medical supplies, etc. were not stored in a more than one hundred (100) sq. hazardous storage area with the fuel powered heater and (2) two gas powered hot water heaters. This deficient practice has the potential for all 13 (R #s 1-13) residents listed on the census provided by the House Manager on 09/17/19, to be at risk of harm, injury, or death if a fire were to occur. The findings are: A. On 09/18/19 at 2:10 pm, during observation of the garage containing (2) two fuel powered hot water heaters and a fuel powered heater, the following items were observed to be stored in the same area of the garage: 1. (21) Unsecured large oxygen cylinder tanks. 2. (4) Secured large oxygen cylinder tanks. 3. Unsecured Christmas decorations including rolls of wrapping paper and various decorations leaning on and at the base of the heater platform. 4. (7) 50 lb bags of sidewalk salt. 5. Numerous large unorganized piles of old household items on the floor including lamps, kitchen items, books, clothing, durable medical equipment, and furniture. 6. (3) Picture frames. B. On 09/18/19 at 2:17 pm, during an interview with the Administrator, she confirmed the above listed items were being stored in in the same area	A 043	A 043 ALL COMBUSTIBLE ITEMS HAVE BEEN REMOVED FROM THE GRAGE WHERE THE WATER HEATERS ARE LOCATED.	9/30/19

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A 043	Continued From page 26 of the garage where the fuel powered hot water heaters (2), and the heater are located.	A 043		
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.47 Based on observation and interview, the facility	A 047		

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A 047	Continued From page 27 has failed to ensure that the emergency lights throughout the building were in working order. This deficient practice has the potential for all 13 (R #s 1-13) residents identified on the census provided by the House Manager on 09/17/19, to be at risk of harm, injury, and/or death it there a fire or other emergency that requires evacuation occurs and residents are not able to see to safely exit the building. The findings are: A. On 09/18/19 at 8:12 am, during observation and tour of the facility, only one of the facility's emergency lights on the North side of the building worked when tested. B. On 09/18/2019 at 8:54 am, during an interview with the Administrator, she confirmed that only 1 of the emergency lights on the North side of the building was in working order.	A 047	A 047 ALL EMERGENCY LIGHTING IS IN WORKING ORDER.	9/30/19
A 050	7 NMAC 8.2.50 Exits EXITS: A. The facility shall have at least two (2) approved exits, that do not involve windows and which are remote from each other. B. Facilities with ten (10) or more residents shall have each exit clearly marked with lighted signs having letters at least six (6) inches high and at least three-quarters (3/4) of an inch wide. Exit signs shall be visible at all times. C. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. D. Exits shall be clear of obstructions at all times. E. Exits, exit paths, or means of egress shall not pass through hazardous areas, garages, storerooms, closets, utility rooms, laundry rooms,	A 050		

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	2141	A. BUILDING: _____ B. WING _____	C 09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF SAN PEDRO, BUILDING C	6401 CORONA NE ALBUQUERQUE, NM 87113

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A 050	Continued From page 28 bedrooms, or spaces subject to locking. F. For facilities with four (4) or more residents, sliding doors are not acceptable as a required exit. EXCEPTION: Assisted living facilities with three (3) or fewer residents may have sliding doors as required exits. G. When the yard gate(s) is part of the exit access and is locked, the gate shall be connected to the fire protection system and release upon activation of the fire/smoke system or shall have the ability to be unlocked at the gate site. [7.8.2.50 NMAC - Rp, 7.8.2.51 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.50 A Based on observation and interview the facility failed to ensure that all there were two approved emergency exits in the facility. If the facility does not have two exits designated as emergency exits then all 13 (R #s 1-13) residents listed on the resident census, provided by the House Manager on 09/17/19, are at risk of harm, injury, or death if a fire or other emergency requiring evacuation were to occur and the residents only have one designated exit door to evacuate from the building. The findings are: A. Record review of the facility evacuation floor plan revealed there was only one (1) designated emergency exit in the facility. B. On 09/17/19 during interview with the Administrator, she confirmed that the facility had only one (1) designated emergency exit.	A 050	A 050 FACILITY SHALL DESIGNATE ON THE EMERGENCY EXIT FLOORPLAN ALL 3 EXITS AS EMERGENCY EXITS.	9/30/19

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A 065	Continued From page 29	A 065		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A B Based on record review and interview, the facility failed to ensure that a fire drill was conducted monthly on each eight (8) hour shift (day, evening, night) per quarter. This deficient practice has the potential to effect all 13 (R #s 1-13) residents identified on the census, provided the House Manager on 09/17/19, to be at risk of harm, injury, or death if Direct Care Staff (DCS) do not know how to safely evacuate the residents from the building if a fire were to occur. The	A 065		

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A 065	Continued From page 30 findings are A. Record request for the facility's fire drill records revealed that there was no documentation in the last 3 months that (1) one fire drill had been conducted every month, with (1) one documented fire drill conducted on each 8 hour (day, evening, night) per quarter. B. On 09/17/19 at 1:51 pm, during an interview with the Administrator, she confirmed that no documented monthly fire drills with (1) one documented fire drill on each eight (8) hour shift (day, evening, night) per quarter had been conducted in the last three (3) months.	A 065	A 065 FIRE DRILLS SHALL BE PERFORMED EVERY MONTH ON ALTERNATING SHIFTS AND PROPERLY DOCUMENTED IN THE FACILITY RECORD. A FIRE DRILL SHALL BE COMPLETED ON EACH SHIFT (MORNING, EVENING AND NIGHT) PER QAURTER.	9/30/19
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere	A 069		

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A 069	Continued From page 31	A 069		

with daily life. It is caused by changes in the brain.
(4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program.
(5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit.
B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process.
(1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services.
(2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider.
C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information.
D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in

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A 069	Continued From page 32	A 069		

compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria:
(1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs;
(2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals:
(a) a physician;
(b) a physician extender (PA or NP);
(c) a licensed nurse (RN or LPN);
(d) the resident if their PCP has approved it;
(e) family or family designee; and
(f) any other individual in accordance with applicable state and local laws.
E. Assessments and reevaluations.
(1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission.
(a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission.
(b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation

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A 069	Continued From page 33 shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate. F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record: (1) the physician ' s diagnosis for admission to a secure environment or a memory care unit; (2) the pre-admission assessment; and (3) the re-evaluation(s). G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round	A 069		

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A 069	Continued From page 34 use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the	A 069		

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A 069	Continued From page 35 additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 G (2) (b) Based on observation and interview, the facility failed to ensure that residents who have dementia (memory loss) could independently access the outdoor courtyard area. This deficient practice has the potential for the all 13 (R #s 1-13) residents identified on the census provided by the House Manager on 09/17/19, to not be able to enjoy the outdoor areas when they want to. The findings are: A. On 09/18/19 at 8:48 am, during observation it was observed that a code was needed to exit the door to the outside courtyard area, preventing residents from being able to independently access the courtyard. B. On 09/18/19 at 9:54 am, during an interview, the Administrator confirmed that the door to the outdoor courtyard area requires a code to exit and that the residents were not able to independently access the courtyard.	A 069	A 069 THE SECURITY SYSTEM WILL BE UPDATED TO REMOVE THE SECURITY CODE REQUIREMENT TO ALLOW ALL RESIDENTS TO ACCESS THE OUTDOOR SPACE FREELY WITHOUT RESTRICTIONS.	12/15/19

REQUIREMENTS FOR ASSISTED LIVING FACILITIES

Facility Name and ID #: Beehive San Pedro Bldg C **Event #** _____ **Date:** _____
Beginning Time 10:50am **Exit: Facility [ ] Phone [ ]**
9/18/19

EXIT CONFERENCE
FACILITY STAFF ATTENDANCE

	Print Name	Signature
Administrator:	Carolyne Sewell	

Email: Carolyneg04@gmail.com Phone: (505) 207-1825

	Print Name	Signature	
Attendees:	Emily Jenkins		emily@beehivenm.com 209-845-5747

Received Survey Monkey ✓

Received Plan of Correction Check list: _____

Received Resident Identifier list: ✓

SURVEYOR(S)

Print Name	Signature
Tammy Fleming	
Erik Cox	Erik Cox

Plan of Correction (POC)
Review Checklist for Assisted Living and Licensed Only Facility Deficiencies

In cases where violations of the rules/regulations are cited, the facility will be provided with an official statement of deficiencies (State Survey Report) and must submit an acceptable POC. An acceptable POC must include the following:

☐	What action the facility will take to correct the deficient practice for those residents/staff found to be affected by the deficient practice. (Residents/Staff identified in the findings).
☐	Address how the facility will identify other residents/staff that have the potential to be affected by the same deficient practice. (Current residents/staff not identified in the findings).
☐	Address what new measures will be put into place or systemic changes that the facility will make to ensure that the deficient practice will not recur and assure continued compliance. (Example: routine inspections and reviews, tracking logs, retraining, etc.).
☐	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Who (what position) will be responsible for monitoring to ensure continued compliance.
☐	Include dates (month, date, year) of when corrective action will be completed in the correction date column (far right). The corrective action completion dates must be acceptable to the Licensing Authority.

If the plan of correction is unacceptable for any reason, the State will notify the facility in writing. If the plan of correction is acceptable, the State will notify the facility by phone, e-mail, etc. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's affirmation of compliance.

Senate Bill (SB) 0335 - 2013

AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Public Health Act is enacted to read:

"ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.--

A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings.

B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them.

C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health."

SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

Refer to 7.8.2.20 A (5) (12); and
Senate Bill 0335 - 2013.

Reference NFPA 99, 1999 Edition

Section 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement).

(a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both)

1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin.

2. * Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose.

3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation.

4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage.

5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7].

6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat.

7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage.

Exception: Shipping crates or storage cartons for cylinders.

8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.

9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)].

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Dear Health Facility Administrator:

Thank you for your hospitality during our recent survey. We are continually looking for ways to improve how we serve facilities and providers in New Mexico.

Please take a moment to complete an online survey regarding your experience with the survey team. You can find the survey at the following link:
https://www.surveymonkey.com/r/DHI_Health_Facility_Customer_Satisfaction_Survey

Your responses are anonymous however we may periodically share the results of these surveys with staff and relevant trade associations.

Sincerely,

Christopher Burmeister
Division of Health Improvement Director

DIVISION OF HEALTH IMPROVEMENT
2040 South Pacheco Street, 2nd Floor, Suite 202 • Santa Fe, New Mexico • 87505
(505) 476-9093 • FAX: (505) 476-8980 • www.dhi.health.state.nm.us

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