STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5842	A. BUILDING: _____ B. WING _____	C 02/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 000	Initial Comments A survey was completed for NMAC 7.8.2 regulations governing Assisted Living facilities for intake 28945. The complaint was substantiated with deficiencies cited.	A 000		
A 019	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises. (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at least three (3) direct care staff persons on duty	A 019		

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A 019	Continued From page 1 and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days. [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that a sufficient number of staff on duty at all times to provide basic care, resident assistance and the required supervision based on the assessment of the resident needs. The findings are: A. Observations from 02/01/13-02/06/13, it was observed that the facility had between 2-3 persons on site from 6am until at least 3:00 pm during observations taken during survey. During this time, the census was 15-16 persons in the licensed building with fifteen (15) of these ambulatory residents and seven (7) with a mental/behavioral diagnosis. B. On 02/01/13 at 2:00 pm during interview with the Administrator, she reported that the facility will staff the facility with three staff by day, 2 staff at night and 2 on the weekends. C. On 02/01/13 at 2:15 pm during interview with Caregiver #20, she reported that Resident #1 needed one on one staffing. D. On 02/05/13 at 9:00 pm during interview with	A 019		

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A 019	Continued From page 2 Caregiver #25, she reported that there is not enough staff to escort residents with only 2 staff. She reports that there is one administrative staff, one staff to run errands and one staff working the floor. E. On 02/06/13 at 7:15 am during interview with Caregiver #27, she reported that the facility is short staffed most of the time.	A 019		
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	A 033		

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A 033	Continued From page 3	A 033		

management hotline and for the state ombudsman program.
D. To protect resident rights, the facility shall:
(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;
(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

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A 033	Continued From page 4 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 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.	A 033		

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A 033	Continued From page 5 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. [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 humane care for 1 (Resident #1) of 16 facility residents. The findings are: A. Facility incident report reads that Caregiver #19 was preparing lunch in the facility kitchen when she heard the door alarm go off. Caregiver #19 went to see who had opened the door. Resident #1 was outside. Resident #1 was brought back inside to the living room. While gathering the residents for lunch, Caregiver #19 noticed that Resident #1 was not present. Caregiver #19 called the second caregiver to watch over the residents while she searched for Resident #1. Caregiver #19 did not find Resident #1 outside the facility area. The police were called and a missing person report put out. Police and staff continued the search until the morning of 01/28/13 for Resident #1. B. In a report to central intake on 01/30/13 at 9:33 am, Police Lieutenant of [Name of Police Department]'s Detective Division, he reported that he was calling to report the possible neglect of Resident #1. Police Lieutenant reports that on Sunday afternoon, 01/27/13 at 1:48 pm, he got a call from Officer responding to the situation. She	A 033		

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reported that Resident #1 had left the facility with no jacket or shoes and had a diagnosis of [redacted] Police Lieutenant reports that he and responding Officer searched the remainder of the evening and could not locate Resident #1. The information regarding Resident #1 was passed to the next shift. On 01/28/13 at approximately 8:00 am Police Sergeant, the night shift supervisor, reported a possible deceased body close to the airport. Apparently, the body was lying on the runway, close to the Westside of the airport. The body was identified as that of Resident #1 with no jacket, shoes, socks and soaked from the rain. Apparently [redacted] left the facility and went west toward the airport. Resident #1 walked around the fenced area and he came across the opening to access the airport runway. The electronic gate was not functioning and so it was left open. Resident #1 went into the secured facility area. There is an open field next to the runway that has red clay mud. It appears Resident #1 was falling and crawled through the red clay mud. Resident #1 got to the runway and passed away.

C. Interview of Caregiver #19 by the police yields that that Caregiver #19 "know that [Resident #1] needs one on one care and know [redacted] Caregiver #20 reports he usually walks to the Westside of town. Caregiver #19 said it was her fault for not checking the alarm the second time it went off. Caregiver #19 reported to police that Resident #1 has [redacted] at least five (5) times in the past. Caregiver #20 confirmed the [redacted] as well. The Administrator reported that she did not learn of the incident until 5:00 pm on 01/27/13.

D. The Police Lieutenant reports that, every month, [the police] get a call and one of the

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A 033	Continued From page 7	A 033		

facility residents has left the facility and the facility staff are unable to locate them. That has kind of always been their history.

E. Medical notes from [Name of Health Center] dated 10/23/13 at 9:58 am indicate that Resident #1 has a [redacted] in which [redacted] lives in the past unaware of the current living situation. It reveals that Resident #1 wanders throughout the day and gets lost easily, unable to recall which room [redacted] sleeps in. Resident #1 continues to be obsessed with the idea of going out to herd sheep, thus [redacted] away from the facility. The diagnosis listed in this assessment is [redacted] without [redacted] but wanders away from home; [redacted] is the most urgent problem at this time due to patient safety issues.

F. Record review revealed a facility incident report dated 10/31/12 regarding Resident #1 in which Resident #12 informed former Caregiver #30 that Resident #1 was not inside the facility. [sic] Caregiver #19 was in the kitchen, Caregiver #19 was in the dining room [sic] but I went outside and searched by foot to the dead end road. Caregiver #30 searched for [redacted] without success and came back to inform [redacted] who didn ' t know [redacted] was missing. Caregiver #19 called the police to inform them. Follow up notes dated 10/31/12 at 1:30 pm reveal that Resident #1 was brought back by the police. [redacted] was found by (supermarket) staff. Resident #1 returned to the facility with [redacted]

G. Behavioral medical record dated 11/2/12 at 9:52 am reveals that Resident #1 has had [redacted] one day and one night. One daytime [redacted] was [redacted] /12 for 1.5 hours when he

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was found by Police four miles from the facility with [redacted] Resident #1 also woke up at 4:00 am and went out the door locking himself out of the facility.

H. On 02/01/13 at 10:00 am during interview with Caregiver #19 she reported that Resident #1 attempted to [redacted] once early in the morning of [redacted]/12 when Caregiver #19 heard the alarm go off, Caregiver #19 caught [redacted] and brought [redacted] back and set [redacted] in the recreation room to watch television. Caregiver #19 was working in the kitchen when the alarm went off a second time and she checked with another resident apparently told her it was not Resident #1 who left. At lunch it was noticed that [redacted] was not there, Caregiver #20 was called by phone and a search conducted. At approximately 12:30 pm, police were notified of Resident #1's [redacted] At 5:00 pm, the Administrator was notified of Resident #1's [redacted]

I. Review of written report by Caregiver #20 read: "I [sic] worked overnight on 01/26/13 from 11pm - 9am. I was scheduled to also work on Sunday morning 01/27/13 from 9:00 am - 6:00 pm. On the morning of 01/27/13 I made breakfast and [sic] had [Resident #1] sit in the dining room 'cause [redacted] has a tendency of walking off. At 9:15 am - 9:30 am my supervisor Caregiver #19 sent me to pick up a resident from the eastside facility [sic]. When I (Caregiver #19) left, [Resident #1] was still (at the facility), I came back around 11:40 am and went into [sic] into the kitchen to give [redacted] the report [sic]. When I walked in, [Caregiver #22] was serving water and [Caregiver #19] was putting mayonnaise on their sandwiches. I didn't see [Resident #1] in there. After I gave [Caregiver #19] the report, [Caregiver

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#19] told me to go to lunch [sic] so I did. When I was at home, I got a call from [Caregiver #19]. [Caregiver #19] asked me if I could come back. I called her at 12:31pm [sic]. I headed back to work, I went to look for [Resident #1] everywhere I could think of. I even went to Zuni, New Mexico thinking [Resident #1] would be headed that way, also checked at every end of town [sic]. I looked for [Resident #1] 'til about 4:45 pm [sic]. [sic] [Resident #1] had not returned."

J. On 02/01/13 at 2:15 pm during interview with Caregiver #20, she reports that on 01/27/13 Resident #1 was at the facility at 9:15 pm-9:30 am when she was at the facility. Caregiver #20 reports that she left and returned to the facility at 11:40 am. At that time, the supervisor at the time, Caregiver #19 told her to go to lunch. Caregiver #20 reports that she left at 11:45 am. Caregiver #20 reports that in that five minute span, she did not actually see Resident #1, so [redacted] may or may not have been in the facility. Caregiver #20 came back during an interrupted lunch break at around 12:40 pm after receiving a phone call from Caregiver #19 summoning her back to the facility because Resident #1 was missing. Apparently, Caregiver #19 had already contacted police help in the matter. Caregiver #20 reports that she looked on the west side of [name of city] until about 4:45 pm. Caregiver #20 reports that Resident #1 had eloped more than twenty (20) times and about seven (7) times on her shift but Resident #1 had always been found. She reports knowing that Resident #1 could scale the fence because Caregivers #19 and #20 had seen him do it in the past. Caregiver #20 reported that Resident #1's [redacted] was getting worse and that the staff constantly had to deal with [redacted] With respect to the facility in general, Caregiver #20 says that there were times that Caregiver

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A 033	Continued From page 10 #19 worked alone in the facility without other staff, there are times when the facility does not have any breakfast food, fresh fruit, salad, gloves, soap, and cleaning supplies to do our job right. Caregiver #20 reports that she and other staff have brought food, laundry soap and other supplies to the facility for the residents. Caregiver #20 further reports that the Administrator has 3 residents living in her personal home who are brought to the facility by day for daytime care and services and thereby increasing the workload for the staff and putting the building over licensed capacity. K. Review of Monthly Reports the facility kept on Resident #1 revealed the following (paraphrased for brevity): 1. 01/11: [Resident #1] was admitted and "walks around most of the night and [redacted] doesn't sleep at night " 2. 04/12: [Resident #1] has [redacted][sic], [redacted] thinks [redacted] is still herding sheep and [redacted] goes out looking for the sheep, [sic] [redacted] left the facility twice this month [sic] 3. 05/12: [Resident #1] has [redacted] [sic], [redacted] thinks [redacted] is still herding sheep and [redacted] goes out looking for the sheep, [sic] [redacted] left the facility twice this month, the first time [redacted] was spotted and picked up by an off duty employee. The second time [redacted] had been gone for some time before the staff noticed and they had to call the police, who found [redacted] three hours later and brought [redacted] back, [sic] [redacted] is [redacted] 4. 10/12: [Resident #1] has adjusted to the facility but no longer knows where [redacted] is most of the time. [Resident #1] has [redacted] [sic] [redacted] thinks [redacted] is still herding sheep and [redacted] goes out looking for the sheep. [sic] [redacted] left the facility many times this month, but the staff have been able to get [redacted] to come back. [sic] [redacted] still tries to	A 033		

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run away because of [redacted] sic] [redacted] is more unhappy as [redacted] has to stay inside so the employees can keep track of [redacted] [sic].

5. 11/11: [Resident #1] has [redacted] [sic], [redacted] thinks [redacted] is still herding sheep and [redacted] goes out looking for the sheep, [sic] [redacted] [sic] is increased

6. 12/12: [Resident #1] has adjusted to the facility but no longer knows where [redacted] is most of the time. [Resident #1] has [redacted] [sic], [redacted] thinks [redacted] is still herding sheep and [redacted] goes out looking for the sheep. [sic] [Resident #1] continues to be seen by Behavioral Health for [redacted] [sic] [redacted] left the facility and the police were called. When [redacted] was brought back, [redacted] had [redacted] and some cuts and scrapes on [redacted] [redacted] is [redacted] [sic], [redacted] forgets where is [redacted] is [sic] [redacted] is increased [redacted] has continued to increase. [sic] [redacted] still tries to run away because of [redacted]

L. Review of a letter dated 02/07/13 regarding Resident #1 from the local police department, it reports that the investigation regarding Resident #1 is still open. It reads that the Administrator and the caregiver on duty (Caregiver #19) knew of Resident #1's history of [redacted] the need for one on one care, hearing the door alarm going off the day leading up to [redacted] and failure to provide sufficient precautions generally in the course of [redacted] care. Finally, the letter relays concern of regular reports of missing elderly clients from the facility.

M. On 02/01/13 at 2:00 pm during interview with the Administrator, she reported that subsequent to the incident regarding Resident #1 and will continue to staff the facility with three staff by day, two (2) staff at night and two (2) on the weekends.

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A 033	Continued From page 12 N. On 02/01/13 at 8:45 am during interview with Caregiver #29, she reported that the alarm is turned off by 8:00 am. O. On 02/01/13 at 2:00 pm during interview with the Administrator, she reported that the alarm is turned on between the hours of 6:00 pm-9:00 am the following morning. P. On 02/01/13 at 2:15 pm during interview with Caregiver #20, she reported that the alarm goes on at 6:00 pm but isn't always on so it is not known who goes in and out. Q. On 02/05/13 at 9:00 pm during interview with Caregiver #25, she reported that the alarm is turned on at 6:00 pm-6:00 am the following morning, generally. However, when Caregiver #19 is supervisor, the alarm could be on or off as Caregiver #19 decides. When the Administrator is not there staff go by Caregiver #19's decision. When neither is there, staff decided if the alarm would be turned on. R. On 02/06/13 at 7:00 am during interview with Caregiver #27, she reported that the alarm is turned on at 6:00 pm-8:00 am, but those times would change when either the Administrator or Caregiver #19 was there. She reports that it was on sometimes 9:00 am-6:00 pm when Caregiver #19 was working but that the alarm has never been on twenty four hours a day, seven days a week (24/7). S. On 02/06/13 at 7:15 am during interview with Caregiver #22, she reported that she had turned the alarm off that morning, which is why it was not on at 6:40 am.	A 033		

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T. On 02/06/13 at 6:40 am during morning observation, it was noted upon entry to the facility that the alarm was not on.

U. On 02/06/13 at 12:33 pm during random observation, it was noted upon entry that the door alarm was not on.

V. On 02/06/13 at 5:00 pm during review of police incident search document, it reveals that from 01/11 through 09/12, there were eight (8) reported police calls for "missing persons" from the facility. In addition, there is documentation of elopement of Resident #1 in 10/12 and again in 01/13.

W. Review of Resident #3's medical record reveals that [redacted] has a diagnosis of [redacted] The Monthly Report for Resident #3 for 12/12 reads that [redacted] needs to be reminded of the day, month and year. [Resident #3] recognizes some of the people that live here and some of the workers but does not appear to know anyone's name. Almost every day, [Resident #3] states that [redacted] will be going home or is going down town which [redacted] never does [sic]. [Resident #3] [redacted] is increasing and [redacted] has been caught trying to walk away and (is) brought back [sic].

X. On 02/01/13 at 12:50 pm - 1:00 pm during random observation outside the facility, Resident #3 was observed to be [redacted] outside of the facility's gated grounds, across the street of the industrial district in which the facility is located. Resident #3 was observed to be walking behind a hotel across the street without facility staff supervision. At 12:54 pm a resident [Resident #12] came out of the back part of the facility and called out to [Resident #3]. During this observation, two semi-trucks for Frito Lay,

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passed by at a reasonable speed, one of which slowed when Resident #3 was seen in the roadway between the hotel and the facility. At no time during this brief observation did any staff of the facility actually cross the street to escort this [redacted] resident back to the facility.

Y. Review of Resident #6 s medical notes dated 09/04/12 reveals that [redacted] has a long history of [redacted] Further, [redacted] was diagnosed with [redacted] by a physician at [name of medical facility] on [redacted]/12. In a follow up medical encounter at [name of medical facility] dated 10/31/12, Resident #6 is noted as having a history of [redacted] and was admitted to the facility for safety reasons due to [redacted]

Z. On 02/05/13 at 3:20 pm it was observed that Resident #6 was seen walking approximately three city blocks away from the facility headed in the general direction of the facility unescorted.

AA. Review of Resident #14's medical encounter on 10/29/13 at [name of medical facility] reveals a diagnosis of [redacted]

BB. On 02/05/13 at 1:10 pm during random observation, it was noted that Resident #14 left the facility and proceeded west down the paved street. At the end of the Cul De Sac, Resident #14 left the paved road and was seen headed into the parking lot of an abandoned hotel at the end of the street. During this observation, Resident #14 was unescorted, and ambulated briskly into the parking lot of the abandoned hotel located along busy Route 66. The area is littered

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A 033	Continued From page 15 with used alcohol containers and appears to be a possible homeless haven and drinking area and was not fenced off for safety to prevent persons or vehicles from entering the general premises. During this time, no staff of the facility was observed pursuing Resident #14 to bring [redacted] back to the facility. CC. Interview with Resident #14 on 02/05/13 at 1:18 pm revealed that [redacted] comes to this area to "just walk around" and reports that [redacted] "doesn't know anybody around here." DD. Review of Resident #4 reveals a diagnosis of [redacted] was admitted to the facility in [redacted] of 2012. Police report dated 09/21/12 confirms that police intervention was used when the Resident #4 was reported as a missing person. In this report, Resident #4 had been missing for 1.5 hours at the time police intervention was sought. Facility staff told police that the resident has a diagnoses of [redacted] Police listed the resident as "missing." Review of the facility monthly report dated 09/12 notes that Resident #4 [redacted] from the facility on [redacted]/12 and was found the next day in [name of city], NM which is approximately forty [redacted] from the facility.	A 033		
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	A 035		

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A 035	Continued From page 16 without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. 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	A 035		

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A 035	Continued From page 17 material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (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,	A 035		

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respiration, blood pressure, blood sugar) as required by the medication order;
(15) the date and time that the medication is self-administered, administered with assistance or is administered;
(16) the initials and signature of the person assisting with or administering the medication;
(17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.);
(18) any refused dose of medication;
(19) any missed dose of medication; and
(20) any medication error.
H. No medication shall be stopped or started without specific orders from the primary care physician.
I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.
J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record.
K. Prescription medication, other than blister packs and unit dose containers, shall be kept 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

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A 035	Continued From page 19 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: Based on observation and interview, the facility failed to ensure that 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. The findings are: A. On 02/06/13 at 7:55 am during observation of the medication pass, it was noted that all medications were pre-poured into souffle cups before being brought out of the locked box by Caregiver #27. B. Interview with Caregiver #27 at 8:00 am on 02/06/13 confirmed that the medications had been pre-poured by some one else prior to the morning shift. C. On 02/6/13 at 2:15 pm during interview with the Administrator, she acknowledged that pre-pouring is not to be done and stated that she would address it.	A 035		

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A 036	Continued From page 20	A 036		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special	A 036		

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A 036	Continued From page 21 diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the	A 036		

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A 036	Continued From page 22 state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting	A 036		

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A 036	Continued From page 23 covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is	A 036		

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maintained.
(5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC.
(6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods.
(7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin.
(8) The facility shall ensure the following:
(a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit;
(b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and
(c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts.
E. Milk.
(1) Raw milk shall not be used.
(2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk.
F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal

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A 036	Continued From page 25 regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from survey dated 03/28/12 Based on observation and interview, the facility failed to provide provide nutritionally balanced meals from the basic food groups in accordance with the recommended daily dietary allowance of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the 2005 USDA dietary guidelines for Americans. The findings are: A. On 03/26/12, during the observation of the noon meal, the following was noted: what appeared to be carrots, cauliflower, macaroni with cheese and white bread. Caregiver #1 reports that the macaroni had beef in it. This surveyor noted very few fragments of beef on one tray. Cupcakes were served for dessert. Based on this surveyor's observation, the meal was very high in carbohydrate content and appeared to lack sufficient quantity of protein to the eye. On 03/26/2012 at 12:30 pm Resident #3 reports that more (quantity) breakfast food is needed for	A 036		

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	5842	A. BUILDING: _____ B. WING _____	C 02/06/2013

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A 036	Continued From page 26 residents. B. On 03/28/12 at 2:05 pm during interview with Caregiver and Employee #3, she reports that residents are receiving foods for meals from the charitable food pantry like breads and pastas which are generally high in carbohydrates. C. On 02/05/13 during the dinner observation at 5:38 pm, it was noted that no fresh fruit aside of two small slices of one strawberry over a bit of yogurt was served and no alternative drinks were offered with the water that was served. D. On 02/06/13 during the breakfast observation at 7:30 am, it was noted that no fresh fruit, vegetable, alternative beverages or pastries were observed, available, offered or given along side the eggs, sausage and potatoes. E. During random observations from 02/01/13-02/06/13 it was observed that between no meal snacks were freely available at the facility or located in a resident common area such as the television room/den. F. On 02/01/13 and 02/05/13 at 6:30 am 8:30 am, 2:00 pm 9:00 pm respectively during interviews with Caregivers #20 and #25 and #28, they report that frequently the facility is really low on breakfast food and food in general. The caregivers report that that it is very rare to have salad, fresh fruit, milk or bacon and most of the vegetables served are frozen. It was reported that staff have seen residents get potato chip snacks out of the dumpster as the facility is situated near a Frito Lay snack outlet. In addition, it was reported that there is more food and more supplies when surveyors are in the building.	A 036		

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A 036	Continued From page 27 G. On 02/05/13 at 5:38 pm during interview with family member of Resident #12, the interviewee reports that Resident #12 asks for foods to be brought which the facility does not provide or offer: sardines, crackers, sodas, coffee and condiments, snack cakes, crunchy type snacks like potato chips. H. Observations of the facility refrigerator and kitchen on 02/01/13 and 02/05/13 at 8:45 am and 10:00 am respectively reveal a lot of starchy potatoes, 1 container of approximately 18 eggs, 1 gallon of milk, various frozen items such as meats, tomatoes and chiles. No roasts or steaks or protein type items was seen as a portion served during any of the dinner observations as per the community standard.	A 036		
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, bedrooms, or spaces subject to locking. F. For facilities with four (4) or more residents,	A 050		

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A 050	Continued From page 28 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: Based on observation and interview, the facility failed to keep exist to the building free from obstructions. This deficient practice has the potential for impeding quick exit from the building in an emergency and could affect the health and safety of all sixteen residents in the building. The findings are: A. During a tour of the facility on 02/01/13 at 8:45 am, the west facing exit door was observed to be taped shut with "Gorilla" tape (which is a stronger version of duct tape.) B. On 02/01/13 at 2:15 pm during interview with Caregiver #20 she reported that Resident #12 tapes the door to prevent cold air from coming in. C. On 02/05/13 at 8:50 am during interview with Caregiver #28 she reported that Resident #12 tapes the door to prevent cold air from coming in. D. During a second tour of the facility on 02/05/13 at 12:10 pm, the west facing exit door was observed to be taped shut with black name brand"Gorilla" tape which is a stronger version of	A 050		

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A 050	Continued From page 29 duct tape. This surveyor attempted to open the door with the full force of body weight and could not open the door. This was also attempted as a backward pushing action with the full force of weight and the door would not open. E. In an interview with the Administrator on 02/06/13 at 2:15 pm, the Administrator acknowledged the door was taped and would address the problem.	A 050		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 070		

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A 070	Continued From page 30 Refer to: 7.1.12.8 NMAC Registry Established; Provider Inquiry Required: Subsection A. "Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. Subsection D. "Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation." Subsection F. "Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency."	A 070		

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A 070	Continued From page 31 Based on record review and interview the facility failed to make inquiry to the Employee Abuse Registry (EAR) prior to Date of Hire for 8 of 10 employee files reviewed (Caregiver #20 through #28). This deficient practice has the potential to affect the health and safety of all residents. The findings are: A. During review employee file, it was noted that Caregiver #20 was hired on 08/24/09, Caregiver #21 was hired on 04/29/11 Caregiver #22 was hired on 08/25/11, Caregiver #23 was hired on 08/06/12, Caregiver #24 was hired on 07/25/12, Caregiver #25 was hired on 08/06/12, Caregiver #26 was hired on 05/16/12, Caregiver #27 was hired on 08/06/09, Caregiver #28 was hired on 08/6/12. No dated EAR report was found during file review. B. Interview with Administration on 02/06/13 at 2:15 pm confirmed that no EAR report had been run on these employees prior to hire. Reference: 7.1.9 NMAC Caregivers Criminal History Screening Requirements. Refer to: 7.1.9.8 NMAC Caregiver and Hospital Caregiver Employment Requirements: Subsection F. "Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B,	A 070		

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A 070	Continued From page 32 D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of contractual relationship with the care provider." Subsection G. "Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules." Based on record review and interview, the facility failed to have documentation that direct care staff had been cleared through the New Mexico Caregivers' Criminal History Screening Program (CCHSP) for 2 employees (Caregiver #21 and Caregiver #28) who were hired to be caregivers for residents of the facility. The findings are: A. Review of records noted that Caregiver #21 who was employed by the facility on 12/14/10 did not have evidence of a CCHSP nationwide or statewide screening clearance letter addressed to the facility as required. Similarly, it was noted that noted that Caregiver #28 who was employed by the facility on 08/06/09 did not have evidence of a CCHSP nationwide or statewide screening clearance letter that was addressed to the facility as required. B. On 02/06/13 at 10:02 am during interview with CCHSP Staff #1, he confirmed that no documentation was on file for Caregiver #21 from the facility in question. C. On 02/06/13 at 2:15 pm during interview with the Administrator, she acknowledged the problem.	A 070		