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 02/13/2018

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 The following deficiencies were cited as a result of a Full-Onsite/Complaint survey completed on 02/13/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake NM#30457 was substantiated, with deficiencies cited.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC.	A 016		

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A 016	Continued From page 1 B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010]	A 016		

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

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A 016	Continued From page 3	A 016		

making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry.
D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.
E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.
F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a

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A 016	Continued From page 4	A 016		

directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.
[7.1.12.8 NMAC - N, 01/01/2006]

7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:
. . .
D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department.
(1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC.

(2) A signed authorization for release of information form.
(3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink.
(4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these

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A 016	Continued From page 5 rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with	A 016		

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A 016	Continued From page 6 the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview the facility failed to ensure that: 1. Staff had been cleared by the Employee Abuse Registry (EAR) prior-to-hire. 2. The application and fingerprints for the Caregiver Criminal History Screening program (CCHSP) were submitted within 20 days of the date of hire. This deficient practice has the potential to affect the safety and welfare of all 16 (R #s 1-16)residents on the census provided by the Administrator on 02/07/18, if they are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents or have a felony conviction. The	A 016		

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A 016	Continued From page 7 findings are: A. Record review of DCS #1's (hire date: 02/09/16) employee file revealed, that the EAR clearance application was not submitted/clearance received until 02/12/16, after the date of hire. There was no documentation that the fingerprints were submitted to the CCHSP within 20 days of hire or clearance letter in the file. B. Record review of DCS #2's (hire date: 08/23/17) employee file revealed, that the EAR application was not submitted/clearance received until 12/05/17, after date of hire. C. On 02/08/18 at 9:30 am, during an interview with the Administrator, she confirmed that the EAR applications were not submitted/clearances received for DCS #s 1 and 2 prior to hire. She also confirmed that there was no documentation in DCS #1's employee file that the fingerprints were submitted to or clearance letter received from the CCHSP.	A 016		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include:	A 017		

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A 017	Continued From page 8 (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A C (1-3) (a-e) (4-12) Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS) received the following training's and provided supporting documentation:	A 017		

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A 017	Continued From page 9 1. 16-hours of supervised training prior to providing unsupervised care for residents. 2. 12-hours of required orientation and annual training. This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 02/07/18, to be at risk of harm or injury if staff have not received training on the proper methods of providing care and services. A. Record review of DCS #1's (date of hire: 02/09/16) employee file revealed: 1. No documentation for 16-hours of supervised training prior to unsupervised care for the residents. 2. The list of orientation/annual training's (original date not legible) that does not contain the signature of DCS #1's stating that she has completed any of the training's. 3. There is no documentation proving that orientation training took place for the following training's: a. Fire safety and evacuation training. b. First aid. c. Confidentiality of records and resident information. d. Infection control. e. Resident rights. f. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. g. Smoking policy for staff, residents and visitors. h. Methods to provide quality resident care. i. Emergency procedures. j. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist	A 017		

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A 017	Continued From page 10	A 017		

with ISPs.

4. There is no documentation proving that annual training took place for the following training's:

a. Fire safety and evacuation training.

b. Confidentiality of records and resident information.

c. Infection control.

d. Resident rights.

e. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC.

f. Smoking policy for staff, residents and visitors.

g. Methods to provide quality resident care.

h. Emergency procedures.

i. Medication assistance.

j. The proper way to implement a resident ISP for staff that assist with ISPs.

B. Record review of DCS #2's (date of hire: 08/23/17) employee file revealed:

1. No documentation for 16-hours of supervised training prior to unsupervised care for the residents.

2. The list of training's for orientation and in-service dated 08/23/17, does not contain the signature of DCS #2's stating that she have completed any of the training's.

3. There is no documentation proving that orientation training took place for the following training's:

a. Fire safety and evacuation training.

b. Safe food handling practices, to include.

i. Instructions in proper storage.

ii. Preparation and serving of food.

iii. Safety in food handling.

iv. Appropriate personal hygiene.

v. Infectious and communicable

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A 017	Continued From page 11 disease control. c. Confidentiality of records and resident information. d. Infection control. e. Resident rights. f. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. g. Smoking policy for staff, residents and visitors. h. Methods to provide quality resident care. i. Emergency procedures. j. Medication assistance, including the certificate of training for staff that assist with medication delivery. k. The proper way to implement a resident ISP for staff that assist with ISPs. C. On 02/08/18 at 2:30 pm, during interview with the Administrator, she confirmed the above findings for DCS #s 1 and 2. That there was no documentation for orientation training's, no documentation for 16- hours of supervised training, and stated that she did not know if the training's actually took place.	A 017		
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.	A 019		

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A 019	Continued From page 12 (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 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: 7.8.2.19 A (3) This is a repeat deficiency from survey dated 02/06/13 Based on record review, observation, and interview, the facility failed to provide the	A 019		

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A 019	Continued From page 13 minimum staffing ratio of one awake staff and one additional staff immediately available on the premises, required during the resident sleeping hours. This deficient practice has the potential to put all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 02/07/17, to be at risk of harm or death if there is not enough Direct Care Staff (DCS) to provide safe, efficient care during this shift. The findings are: A. On 02/06/17 at 9:25 pm, during observation and interview the facility only one DCS was on duty caring for 16 residents. On 02/06/17 at 9:25 pm, during interview with DCS #2, she confirmed that she is the only DCS on duty that evening and her shift ends at 12:00 am-midnight. B. Record review of the facility staffing schedule, dated 01/30/18 to 02/24/18, revealed, on 02/06/18 to 02/12/18 there was only one DCS on duty during 9:00 pm to 12:00 am and one DCS on duty during 12:00 am to 7:00 am, to care for 16 residents. C. On 02/06/17 at 9:38 pm, during interview with the Administrator, she confirmed that there were only one DCS working from 9:00 pm to 12:00 am, and 12 am to 7 am shifts to care for 16 residents.	A 019		
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	A 020		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 020	Continued From page 14 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; (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:	A 020		

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A 020	Continued From page 15 (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 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	A 020		

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A 020	Continued From page 16 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 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	A 020		

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A 020	Continued From page 17 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] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (2) (5) (8-12) (a-e) (i) (ii) (iii) (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 admission agreements were reviewed for accuracy and completeness, were missing the following required information: 1. Facility's narrative. 2. Refund policy for death, transfer, voluntary or involuntary discharge. 3. Facility's staffing ratio. 4. Written authorization for staff to assist with medications.	A 020		

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A 020	Continued From page 18 5. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements. 6. Bed hold policy. 7. The admission agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: a. There shall be a fifteen (15) day written notice of termination given. b. Resident fail to pay. c. Facility fail to operate. d. Resident's health improves. e. Termination without prior notice for emergency situations; i. Transfer or discharge for necessary for safety and welfare. ii. Residents needs cannot safely be met by the facility. iii. Safety and health of other residents and staff are endangered. 8. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. This deficient practice has the potential for residents to be at risk of: 1. Not being aware of the facility's services provided. 2. Resident's estate or responsible party unaware of any refund that may be due. 3. Being misinformed regarding the number of direct care staff that will be available to assist residents on each shift. 4. Being misinformed about the direct care staff ability to administer medications. 5. Not being informed of their rights and responsibilities and the process of staff training requirements in reporting of injuries or incidents of suspected Abuse, Neglect or Exploitation.	A 020		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 020	Continued From page 19 6. Unaware of the facility's bed-hold policy and the additional financial responsibilities associated. 7. Being discharged before an appropriate placement was found. 8. Being charged for new/changed care services without the appropriate 30-day notice The findings are: A. Record review of R# 1's admission agreements (dated [redacted]/17 and [redacted]/17) revealed, missing information for: 1. Facility's narrative. 2. Refund policy for death, transfer, voluntary or involuntary discharge. 3. Facility's staffing ratio. 4. Written authorization for staff to assist with medications. 5. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements. 6. Bed hold policy 7. The admission agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: a. There shall be a fifteen (15) day written notice of termination given. b. Resident fail to pay. c. Facility fail to operate. d. Resident's health improves. e. Termination without prior notice for emergency situations; i. Transfer or discharge for necessary for safety and welfare. ii. Residents needs cannot safely be met by the facility. iii. Safety and health of other residents and staff are endangered. 8. Facility shall provide a thirty (30) day	A 020		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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A 020	Continued From page 20 written notice to residents regarding any changes in the cost of services. B. Record review of R# 2's admission agreement (dated [redacted]/17) revealed, missing information for: 1. Facility's narrative. 2. Refund policy for death, transfer, voluntary or involuntary discharge. 3. Facility's staffing ratio. 4. Written authorization for staff to assist with medications. 5. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements. 6. Bed hold policy 7. The admission agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: a. There shall be a fifteen (15) day written notice of termination given. b. Resident fail to pay. c. Facility fail to operate. d. Resident's health improves. e. Termination without prior notice for emergency situations; i. Transfer or discharge for necessary for safety and welfare. ii. Residents needs cannot safely be met by the facility. iii. Safety and health of other residents and staff are endangered. 8. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. C. Record review of R# 3's admission agreement [redacted]/15) facility list revealed, missing information for:	A 020		

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A 020	Continued From page 21 1. Facility's narrative. 2. Refund policy for death, transfer, voluntary or involuntary discharge. 3. Facility's staffing ratio. 4. Written authorization for staff to assist with medications. 5. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements. 6. Bed hold policy 7. The admission agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: a. There shall be a fifteen (15) day written notice of termination given. b. Resident fail to pay. c. Facility fail to operate. d. Resident's health improves. e. Termination without prior notice for emergency situations; i. Transfer or discharge for necessary for safety and welfare. ii. Residents needs cannot safely be met by the facility. iii. Safety and health of other residents and staff are endangered. 8. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. D. Record review of R# 4's admission agreement (dated [redacted]/07) revealed, missing information for: 1. Facility's narrative. 2. Refund policy for death, transfer, voluntary or involuntary discharge. 3. Facility's staffing ratio. 4. Written authorization for staff to assist with medications.	A 020		

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A 020	Continued From page 22 5. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements. 6. Bed hold policy 7. The admission agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: a. There shall be a fifteen (15) day written notice of termination given. b. Resident fail to pay. c. Facility fail to operate. d. Resident's health improves. e. Termination without prior notice for emergency situations; i. Transfer or discharge for necessary for safety and welfare. ii. Residents needs cannot safely be met by the facility. iii. Safety and health of other residents and staff are endangered. 8. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. E. On 02/08/18 at 10:30 am, during interview with the Administrator, she confirmed that the required above information was missing from R #s 1-4 admission agreements.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be	A 021		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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A 021	Continued From page 23 readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status;	A 021		

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A 021	Continued From page 24 (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's	A 021		

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A 021	Continued From page 25 personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 A (1-4) B (1) (2) 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 admission agreements, resident evaluations, and Individual Services Plans (ISP) were reviewed for compliance, were accurate, complete, and included all required information/documentation. This deficient practice has the potential for residents to be at risk of harm if: 1. They are not receiving complete and accurate information regarding their rights and	A 021		

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A 021	Continued From page 26	A 021		

responsibilities upon admission to the facility.

2. Their evaluations are not being completed prior to admission, signed as reviewed and updated by a Licensed Nurse (LN) or Physician Extender (PE) at a minimum of every 6 months, or if a change in condition occurs.

3. The evaluations do not include a physicians physical examination report, then the facility will have updated information to ensure an accurate evaluation of the needs of the resident.

4. The ISP's were not updated

The findings are:

Findings related to admissions agreement
A. Record review of R# 1's admission agreements (dated [redacted]/17 and [redacted]/17) revealed, missing information for:

1. Facility's narrative.

2. Refund policy for death, transfer, voluntary or involuntary discharge.

3. Facility's staffing ratio.

4. Written authorization for staff to assist with medications.

5. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements.

6. Bed hold policy

7. The admission agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances:

a. There shall be a fifteen (15) day written notice of termination given.

b. Resident fail to pay.

c. Facility fail to operate.

d. Resident's health improves.

e. Termination without prior notice for emergency situations;

i. Transfer or discharge for necessary for safety and welfare.

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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 021	Continued From page 27	A 021		

ii. Residents needs cannot safely be met by the facility.
iii. Safety and health of other residents and staff are endangered.
8. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services.

B. Record review of R# 2's admission agreement (dated [redacted]/17) revealed, missing information for:
1. Facility's narrative.
2. Refund policy for death, transfer, voluntary or involuntary discharge.
3. Facility's staffing ratio.
4. Written authorization for staff to assist with medications.
5. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements.
6. Bed hold policy
7. The admission agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances:
a. There shall be a fifteen (15) day written notice of termination given.
b. Resident fail to pay.
c. Facility fail to operate.
d. Resident's health improves.
e. Termination without prior notice for emergency situations;
i. Transfer or discharge for necessary for safety and welfare.
ii. Residents needs cannot safely be met by the facility.
iii. Safety and health of other residents and staff are endangered.
8. Facility shall provide a thirty (30) day written notice to residents regarding any changes

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 02/13/2018

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 021	Continued From page 28 in the cost of services. C. Record review of R# 3's admission agreement (dated [redacted]/15) facility list revealed, missing information for: 1. Facility's narrative. 2. Refund policy for death, transfer, voluntary or involuntary discharge. 3. Facility's staffing ratio. 4. Written authorization for staff to assist with medications. 5. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements. 6. Bed hold policy 7. The admission agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: a. There shall be a fifteen (15) day written notice of termination given. b. Resident fail to pay. c. Facility fail to operate. d. Resident's health improves. e. Termination without prior notice for emergency situations; i. Transfer or discharge for necessary for safety and welfare. ii. Residents needs cannot safely be met by the facility. iii. Safety and health of other residents and staff are endangered. 8. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. D. Record review of R# 4's admission agreement (dated [redacted]/07) revealed, missing information for: 1. Facility's narrative.	A 021		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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 021	Continued From page 29 2. Refund policy for death, transfer, voluntary or involuntary discharge. 3. Facility's staffing ratio. 4. Written authorization for staff to assist with medications. 5. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements. 6. Bed hold policy 7. The admission agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: a. There shall be a fifteen (15) day written notice of termination given. b. Resident fail to pay. c. Facility fail to operate. d. Resident's health improves. e. Termination without prior notice for emergency situations; i. Transfer or discharge for necessary for safety and welfare. ii. Residents needs cannot safely be met by the facility. iii. Safety and health of other residents and staff are endangered. 8. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. E. On 02/08/18 at 10:30 am, during interview with the Administrator, she confirmed that the required above information was missing from R #s 1-4 admission agreements. Findings related to evaluations F. Record review of R #1's initial evaluation (dated 01/18/17) revealed: 1. It was not completed within 15-days prior to [redacted] admission to the facility on [redacted]/17.	A 021		

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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 021	Continued From page 30 2. There was no documentation that a medical evaluation by a physician or a physician extender had been completed annually or anytime in the file. 3. The evaluation was not signed as reviewed by a LN or PE, at a minimum of every six (6) months or when a significant change in condition occurs. 4. The initial and only evaluation was completed on 01/18/17 - was due for review on 06/18/17 and again on 12/12/18. G. Record review of R #2's initial evaluation (dated 10/10/17) revealed: 1. It was not completed within 15-days prior to [redacted] admission to the facility on [redacted]/17. 2. There was no documentation that a medical evaluation by a physician or a physician extender had been completed annually or anytime in their file. 3. The evaluation was not signed as reviewed by a LN or PE, at a minimum of every six (6) months or when a change in condition occurs. H. Record review of R #3's evaluation (dated 01/17/18) revealed: 1. There was no medical evaluation by a physician or a physician extender done annually or at anytime in their file. 2. The evaluation was not signed as reviewed by a LN or PE, at a minimum of every six (6) months or when a change in condition occurs. I. Record review of R #4's evaluation (dated 01/20/17) revealed: 1. There was no medical evaluation by a physician or a physician extender done annually or anytime in their file. 2. The evaluation was not signed as reviewed by a LN or PE, at a minimum of every six (6)	A 021		

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A 021	Continued From page 31	A 021		

months or when a change in condition occurs.

3. The first found evaluation was done on 12/05/14, the second was on 08/13/15, the 3rd evaluation was on 06/26/16, the fourth and last documented evaluation was on 01/20/17.

J. On 02/13/18 at 8:45 am, during an interview with the Administrator, she confirmed the evaluations were being completed late and were not reviewed by a LN or PE.

Findings related to ISP's

K. Record review of R #1's ISP (dated 04/20/17) revealed that the:

1. The ISP did not address the following areas of need as identified in the residents evaluation (dated 01/18/18), including that R #1:

a. Is unable to administer [redacted] own medication.

b. Needs assistance with activities of daily living (ADL's).

c. Is incontinent of urine, but does not mention it on the ISP.

d. Needs encouragement to participate in activities.

2. The ISP was not reviewed by a registered nurse, licensed practical nurse or a physician extender.

3. The ISP was not revived/revised every 6 months or when there is a significant change in condition and the last update was on 04/20/17.

L. Record review of R #2's ISP (no date) revealed:

1. The ISP was blank. [redacted] move in date was [redacted]/17. [redacted] had an evaluation dated 10-10-17, but only had a blank ISP in [redacted] file.

M. Record review of R #3's ISP (dated 04/20/17) revealed:

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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 021	Continued From page 32 1. The ISP in R #3's file did not have [redacted] name written on it and no one could verify that it was R #3's ISP or if [redacted] even had one. N. Record review of R #4's last ISP (dated 04/20/17 revealed: 1. The ISP did not address the following areas of need, as identified in the residents evaluation (dated 01/20/17), including: 2. The ISP was not revived/revised every 6 months or when there is a significant change in condition. 3. The ISP does not give a clear description of all services to be provided, ISP review dated 08/13/15 states under Needs section, "continue present care noted & changes". 4. The ISP does not give a written description of all services to be provided, the section is blank, dated 08/13/15. 5. There is no documentation to show the facility's determination that it can meet the needs of the resident. 6. The ISP does not state the level of assistance that the resident will require with activities of daily living. 7. The ISP does not state that a crisis prevention/intervention plan when indicated by diagnosis or behavior, as shown on R #4's evaluation. O. On 02/13/18 at 2:45 pm, during an interview with the Administrator, she confirmed the missing information on the ISP's. P. Record review of R #s 1-4 resident records revealed they were missing the physical examination report which should be completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician's assistant and shall be on file in the resident's	A 021		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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A 021	Continued From page 33 record within ten (10) days of admission. Q. Record review of R #s 1-4 resident records revealed they were not stored in an organized, accessible and permanent manner. R. Record review of the facilities policy and procedure manual revealed that it did not contain a policy and procedure relating how the facility will maintain and ensure the confidentiality of resident records. S. On 02/13/18 at 3:00 pm, during an interview with the Administrator, she confirmed the records were not organized and missing the information.	A 021		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the	A 022		

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A 022	Continued From page 34 applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies: (a) an emergency that affects just the facility; and (b) a region/area wide emergency; (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC); (12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and (13) vaccination records for pets in the facility.	A 022		

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A 022	Continued From page 35 B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or	A 022		

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A 022	Continued From page 36 PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide	A 022		

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A 022	Continued From page 37 assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (10) (a) (b) C (2, 3, 5, & 6) D (1-3) (8) (10) (20) (23) Based on record review and interview, the facility failed to have all the required facility specific written policies and procedures for staff and residents to review. If the facility does not ensure all staff are receiving proper training and management direction (on all the required training's, policies, and procedures), then the 16 (R #s 1-16) residents listed on the census provided by the Administrator on 02/07/18, are at risk for harm due to staff not having the required information to ensure resident health, safety, and welfare. The findings are: A. Record request for the facility's written emergency plans revealed that they were missing: 1. Written emergency plans (Policies and procedures): a. For medical emergencies.	A 022		

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A 022	Continued From page 38 b. Power failure, fire or natural disaster. i. Plans shall include evacuation ii. Persons to be notified. iii. Emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies. iv. Plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency. 2. The emergency preparedness plan shall address two types of emergencies; a. An emergency that affects just the facility and; b. A region/area wide emergency emergency evacuation plan. B. Record request for copy of the facility "rules", given to prospective residents prior to admission revealed that there was no book or folder containing the facility rules available for review, however, in 2 (R #'s 2 & 3) resident files there was only a copy of resident rights, and there were none found in the remaining residents files. The following rules were missing: 1. Resident use of facility telephone or personal cell phone. (does not mention right to communicate privately/private phone conversation) 2. Resident use of television, radio, stereo and cd. (only states no loud music or TV) 3. Meal availability and times. 4. Resident use of common areas. C. Record request for written policies and procedures concerning the following areas were missing: 1. Actions to be taken in case of accidents or emergencies (not specific). 2. Policy and procedure for updating and	A 022		

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A 022	Continued From page 39 consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission. 3. Policy for medication errors. 4. Reporting and investigating complaints to the incident management bureau. 5. Mealtimes, daily snacks, menus, special diets, resident's personal preference for eating alone or in the dining room setting. D. On 02/07/18 at 9:20 am, during an interview with the Administrator, she confirmed the above missing facility rules and policy and procedures.	A 022		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc;	A 025		

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A 025	Continued From page 40 (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010]	A 025		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 41 This REQUIREMENT is not met as evidenced by: 7.8.2.25 A D E 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 evaluations were reviewed for compliance that they: 1. Were completed within fifteen (15) days prior to admission. 2. Included a history and physical examination and evaluation report by a physician or a physician extender within six (6) months of admission and annually thereafter. 3. Were updated and reviewed by a Licensed Nurse (LN) and/or a Physician Extender (PE) at a minimum of every 6 months or when a change of condition occurred. These deficient practices could cause harm to residents by not receiving the care and services they need, if the Direct Care Staff do not know what care and services they need to provide for the residents. The finding are: A. Record review of R #1's initial evaluation (dated 01/18/17) revealed: 1. It was not completed within 15-days prior to [redacted] admission to the facility on [redacted]/17. 2. There was no documentation that a medical evaluation by a physician or a physician extender had been completed annually or anytime in the file. 3. The evaluation was not signed as reviewed by a LN or PE, at a minimum of every six (6) months or when a significant change in condition occurs. 4. The initial and only evaluation was completed on 01/18/17 - was due for review on 06/18/17 and again on 12/12/18.	A 025		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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A 025	Continued From page 42 B. Record review of R #2's initial evaluation (dated 10/10/17) revealed: 1. It was not completed within 15-days prior to [redacted] admission to the facility on [redacted]/17. 2. There was no documentation that a medical evaluation by a physician or a physician extender had been completed annually or anytime in their file. 3. The evaluation was not signed as reviewed by a LN or PE, at a minimum of every six (6) months or when a change in condition occurs. C. Record review of R #3's evaluation (dated 01/17/18) revealed: 1. There was no medical evaluation by a physician or a physician extender done annually or at anytime in their file. 2. The evaluation was not signed as reviewed by a LN or PE, at a minimum of every six (6) months or when a change in condition occurs. D. Record review of R #4's evaluation (dated 01/20/17) revealed: 1. There was no medical evaluation by a physician or a physician extender done annually or anytime in their file. 2. The evaluation was not signed as reviewed by a LN or PE, at a minimum of every six (6) months or when a change in condition occurs. 3. That there was no documentation of an evaluation being completed since 01/20/17. E. On 02/13/18 at 8:45 am, during an interview with the Administrator, she confirmed the evaluations were being completed late and were not reviewed by a LN or PE.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan	A 026		

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A 026	Continued From page 43 INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC,	A 026		

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A 026	Continued From page 44 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (1-3) B (1-2) (9-10) Based on record review and interview the facility failed to ensure for 4 residents (R #s 1-4) of 4 (R #s 1-4) residents whose Individual Service Plans (ISP's) were reviewed for compliance failed to ensure the ISP: 1. Was completed within 10 days of admission and at a minimum of every 6 months or when a significant change in condition occurred. 2. Addressed all areas of need identified in their evaluations. 3. Were signed as reviewed/revised by a Licensed Nurse (LN) or a Physician Extender (PE) at a minimum or every 6 months or when there is a significant change in condition. 4. There is no crisis intervention plan for unacceptable behaviors in place to keep other residents and staff safe. This deficient practice could cause harm to the residents if the Direct Care Staff (DCS) do not know what care and services need to be provided to the residents. The findings are: A. Record review of R #1's ISP (dated 04/20/17) revealed that the: 1. The ISP did not address the following areas of need as identified in the residents evaluation (dated 01/18/18), including that R #1: a. Is unable to administer [redacted] own medication.	A 026		

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A 026	Continued From page 45 b. Needs assistance with activities of daily living (ADL's). c. Is incontinent of urine. d. Needs encouragement to participate in activities. e. [redacted] 2. The ISP was not signed as reviewed/revised by a LN or PE at a minimum of every 6 months or when there is a significant change in condition and the last update was on 04/20/17. B. Record review of R #2's ISP (no date) revealed, the ISP form was blank. There was no previous ISP's found in R #2's file since [redacted] resident evaluation dated 10/10/17. C. Record review of R #3's ISP (dated 04/20/17) revealed, it did not have [redacted] name written on it and no one could verify that it was R #3's ISP. D. Record review of R #4's ISP (dated 04/20/17) revealed: 1. The ISP was not signed as reviewed/revised by a LN or PE at a minimum of every 6 months or when there is a significant change in condition. 2. The ISP does not give a clear description of all services to be provided, ISP review (dated 08/13/15) states under the "Need" section, "continue present care noted & changes". 3. The ISP review (dated 08/13/15) does not give a written description of all services to be provided, the section is blank. 4. The ISP does not state the level of assistance that the resident will require with activities of daily living. 5. The ISP does not include a crisis prevention/intervention plan when indicated by	A 026		

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A 026	Continued From page 46 diagnosis or behavior, as shown on R #4's evaluation. E. On 02/13/18 at 2:45 pm, during an interview with the Administrator, she confirmed: 1. The missing ISP for R #2. 2. That the ISP in R #3's file could not be confirmed as R #3's ISP. 3. The missing information for R #s 1 and 4 ISP's. 4. There was no crisis prevention/intervention plan for R #4	A 026		
A 027	7 NMAC 8.2.27 Resident Activities RESIDENT ACTIVITIES: Each facility shall provide or make available recreational and social activities appropriate to the residents ' abilities that meet their psychosocial needs and are relevant to their social history; including a balance of cognitive, reminiscence, physical and social activities. The facility shall post the activities and encourage residents to participate. [7.8.2.27 NMAC - Rp, 7.8.2.28 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.27 Based on record review, observation, and interview, the facility failed to have a current activities calendar posted and/or provide activities that meet the needs of the residents. This deficient practice has the potential to affect the psychosocial well being of all 16 (R #s 1-16) residents identified on the census provided by Administrator on 02/07/18, through isolation,	A 027		

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A 027	Continued From page 47 boredom, and depression. The findings are: A. Record review of the activity calendar dated "January 2018" revealed, it was still posted in February 2018. B. On 02/08/18 from 2:00 pm to 4:00 pm, during observation of the multipurpose room, no organized activities were observed being conducted. C. On 02/08/18 at 4:15 pm, during interview with the Administrator, she confirmed that the activity calendar is for January 2018 and that there were no activities taking place. She stated that the residents watch television and that it is hard to do activities with them because they don't like the activities the facility offers.	A 027		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing	A 032		

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A 032	Continued From page 48 authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32. A B 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form	A 032		

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A 032	Continued From page 49 consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure that all incidents of suspected or known resident abuse, neglect, or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and others were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. That an internal investigation was conducted and a follow-up report was submitted within 5 business days to the Licensing Authority. This deficient practice has the potential all 16 (R #s 1-16) residents identified on the census, provided by the Administrator on 02/07/18, to be at risk of being abused, neglected, and/or not receiving needed medical care and services if incidents are not being reported as required. If the facility is not conducting internal investigations and submitting their findings to the Licensing Authority, then residents are at risk of continued suffering and further injury if there is no oversite of the care and services the facility is providing. The findings are:	A 032		

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A 032	Continued From page 50 A. Record review of facility's internal incidents reports revealed the following: 1. R #6's incident report dated 08/01/17, stated on [redacted]/17 that resident had fell against wall hurting [redacted] face and then again on [redacted]/17, [redacted] fell to the floor in [redacted] room, hurting [redacted] left knee, complained about being sore, and had a small cut over [redacted] right eye. Resident was taken to a medical facility. 2. R #7's incident report dated 01/10/18, stated that resident had an unwitnessed fall with injury of unknown source, was found sleeping on the floor. DCS #5 woke [redacted] up and helped [redacted] back into bed. DCS #5 woke resident up at 7:30 am resident had two bumps on [redacted] forehead. 3. R #8's incident report dated 07/26/17, states that resident got upset with another resident because [redacted] asked for [redacted] plate to clear from the table. R #8 left dining room and was yelling and throwing things. [redacted] continued to [redacted] room and threw all [redacted] belongings into the hallway. After that, [redacted] continued outside where [redacted] threw chairs, garbage can, glass bottles, rocks and chip bags into the parking area. [redacted] then left the facility. 4. R #9's incident report dated [redacted]/17, states that resident went into the bathroom and tripped over [redacted] feet. [redacted] fell in front of the first stall. Landed on [redacted] right side. staff member helped resident up. Resident stated [redacted] was fine and went back to [redacted] room. A few minutes later resident complained that [redacted] shoulder was hurt. Resident was taken to emergency room. 5. R #10's incident report dated 08/07/17, stated that on 08/05/17 residents were in the living room and started yelling. R #10 was yelling another person went into the living room to see what was happening and R #10 began yelling at [redacted] Both residents went into the hallway and	A 032		

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A 032	Continued From page 51 picked up the mop while yelling at each other. The mop dropped and both residents went back to their rooms. The [redacted] resident in the living room showed staff member [redacted] left leg which had a bruise developing. Resident stated that R #10 threw [redacted] The police were called. B. On 02/08/18 at 0:55 am, during an interview with the Administrator, she confirmed that the above incidents for R #s 6-10 were not reported to the Licensing Authority. She also confirmed that no 5 day follow-up investigation reports were completed and/or submitted to the Licensing Authority.	A 032		
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;	A 033		

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A 033	Continued From page 52 (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (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 033		

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A 033	Continued From page 53 (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written 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	A 033		

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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 033	Continued From page 54 recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (1) (4) (11) (a) and refer to NFPA (National Fire Prevention Association) 72 - 2010 14.3 Inspection. 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. From table 14.3.1 Control equipment: fire alarm systems monitored for alarm, supervisory, and trouble signals: (a) Fuses; (b) Interfaced equipment; (c) Lamps and LEDs; (d) Primary (main) power supply, Annually. Based on record review, observation, and interview, the facility failed to ensure: 1. The fire alarm system is in good working order and not in trouble mode.	A 033		

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 02/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 033	Continued From page 55 2. Dried and frozen food stored in the kitchen was not out-dated. 3. The facility's interior was cleaned as to maintain a clean and sanitary environment and furniture in good repair. This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 02/07/18 and all occupants in the building to be at risk of harm, injury, illnesses or death if the: 1. Fire alarm does not alert residents and occupants that a fire is present. 2. Food served to residents has passed its expiration date. 3. Facility is not maintained to provide a clean, safe, and sanitary environment, and kept the furniture in good repair. Findings related to the Fire Alarm Panel. A. On 02/06/18, at 9:15 pm, during observation and a tour of the facility, the fire alarm panel was observed to be in trouble mode. B. On 02/06/18, at 9:38 pm, during interview the Administrator, she confirmed that the fire panel was in trouble mode. Findings related to Expired food C. On 02/07/18 at 10:26 am, during observation of the kitchen cabinet and freezer, the following foods were expired: 1. 6-5.5oz (ounce) packets of pudding cups, expiration date 10/23/17. 2. 1-8 oz container of powdered chocolate drink, expiration date of 01/2015. 3. 1-8 packet of hamburger rolls, expiration date of 01/28/2016	A 033		

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A 033	Continued From page 56 4. 6-loaves of bread, expiration dates: 12/31/17, 01/01/18, 01/11/18, 01/13/18, and 2 dated 01/14/18. 5. 2-french breads, expiration date 01/25/18. 6. 2-packages (12-count) of hot dog buns, expiration dated 02/01/18 and 12/31/17. 7. 1-package (7-count) of barbeque pork patties, expiration date 09/01/17. 8. The following food items in the freezer, were not dated or labeled: a. 1-package (8-count) of french bread. b. 1-package (5-count) of cooked chicken patties. c. 1-package (10-count) of beef patties. D. On 02/07/18 at 10:40 am, during an interview with the Assistant Administrator, he confirmed that the following foods were expired: 1. 6-5.5oz (ounce) packets of pudding cups, expiration date 10/23/17. 2. 1-8 oz container of powdered chocolate drink, expiration date of 01/2015. 3. 1-8 packet of hamburger rolls, expiration date of 01/28/2016 4. 6-loaves of bread, expiration dates: 12/31/17, 01/01/18, 01/11/18, 01/13/18, and 2 at 01/14/18. 5. 2-french breads, expiration date 01/25/18. 6. 2-packages (12-count) of hot dog buns, expiration dated 02/01/18 and 12/31/17. 7. 1-package (7-count) of barbeque pork patties, expiration date 09/01/17. 8. The following foods items in the freezer, were not dated or labeled: a. 1-package (8-count) of french bread. b. 1-package (5-count) of cooked chicken patties. c. 1-package (10-count) of beef patties. Findings related to an unsanitary environment	A 033		

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A 033	Continued From page 57 E. On 02/07/18 at 10:55 am, during observation of the community bathroom in between residents rooms #8 and #9, the bathroom had a foul smell of odor. F. On 02/07/18 at 10:57 am, during interview with the Administrator, she confirmed that the bathroom had a foul smell of odor and that the drain on the floor was backed up. G. On 02/07/18 at 11:00 am, during observation of R #5's bathroom the shower had black mold around the bottom of the cubicle. H. On 02/07/18 at 11:03 am, during interview with the Administrator, she confirmed that R #5's bathroom the shower cubicle had black mold around the bottom. I. On 02/07/18 at 11:40 am, during observation of the multipurpose room: 1. Three (3) chairs seating area pads were split, the filling was bulging out and smelled of urine. 2. The carpet was dirty with stains and smelled of urine. 3. The vent on the ceiling was covered with dust and dirt. 4. The window blinds were covered with dust and stains. J. On 02/07/18 at 11:49 am, during an interview with the Administrator, she confirmed that the multipurpose room: 1. Three (3) chairs seating pads were split, the filling was bulging out, and smelled of urine. 2. The carpet was dirty with stains and smelled of urine.	A 033		

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A 033	Continued From page 58 3. The vent on the ceiling was covered with dust and dirt. 4. The window blinds were covered with dust and stains.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate 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	A 034		

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A 034	Continued From page 59 name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a 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	A 034		

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A 034	Continued From page 60 maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (1) (3) Based on observation and interview, the facility failed to ensure the health and safety for all 16 residents (R #'s 1-16) of 16 (R #s 1-16) residents currently residing at the facility by: 1. Not having a locked medication refrigerator. 2. Storing insulin with food in the kitchen refrigerator.	A 034		

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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 034	Continued From page 61 This deficient practice has the potential for residents to be harmed if they were to have access to the unsecured medications. If food and medication were to become contaminated then residents may become ill. The findings are: A. On 02/07/18 at 10:33 am, during observation of the kitchen 1 vile of insulin (diabetes) 100 units was observed to be stored in the kitchen refrigerator with food. B. On 02/07/18 at 10:45 am, during interview with the Administrator, she confirmed that there was one (1) vile of insulin 100 units was being stored in the kitchen refrigerator with food and that she stated that the facility does not have a refrigerator for medications.	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	A 035		

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A 035	Continued From page 62 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 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	A 035		

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A 035	Continued From page 63 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, 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;	A 035		

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A 035	Continued From page 64 (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 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]	A 035		

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A 035	Continued From page 65	A 035		

This REQUIREMENT is not met as evidenced by:
7.8.2.35 G (4) (5) (8) (12)

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 included:

1. The diagnosis or the reason for the medication.
2. Both the brand/generic names of the medication.
3. The strength of the medication.
4. The start and end date of the medication.

If the MARs do not include all the required information, then residents may be at risk of harm, illness, and need medical treatment if medication errors occur because vital information is missing on the MAR. The findings are:

A. Record review of R #1's [redacted]/18 to [redacted]/18 MAR revealed, it was missing the brand/generic name and the start/end dates listed for the following medications:

[redacted]

B. Record review of R #2's [redacted]/18 - [redacted]/18 MAR revealed:

[redacted]

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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 035	Continued From page 66	A 035		

[redacted]

C. Record review of R #3's [redacted]/18 - [redacted]/18 MAR revealed, that the brand/generic names and the start/end date were missing for the following medications:

[redacted]

D. Record review of R #4's [redacted]/18 to [redacted]/18 MAR revealed:

1. It did not include the brand/generic names

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 035	Continued From page 67 and the start/end dates for the following medications: [redacted] (supplement) No brand/generic name 2. The start/end dates were missing for the following medications: [redacted] E. On 02/08/18 at 2:30 pm, during an interview with the Administrator, she confirmed the for missing information on the MARs for R #s 1-4.	A 035		
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.	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 036	Continued From page 68 (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with 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;	A 036		

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 02/13/2018

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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 036	Continued From page 69 (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) 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,	A 036		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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A 036	Continued From page 70 rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean 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.	A 036		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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A 036	Continued From page 71 (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be 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.	A 036		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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 036	Continued From page 72 (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 C (4) (5) D (3) (5) Based on observation and interview the facility failed to ensure that: 1. The garbage container is covered with a	A 036		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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 036	Continued From page 73	A 036		

tight fitting lid/cover.
2. Staff wear a hairnet/cap while preparing/cooking food.
3. Food is discarded after the "sell by" or "used by" date has expired.
4. Food stored in the freezer is dated and labeled.
5. Residents medication is not stored in the refrigerator with food.

This deficient practice has the potential to negatively affect the health and safety for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 02/07/18 to be at risk of:
1. Contracting foodborne illnesses if:
a. Food is not prepared and/or served in a clean and sanitary environment.
b. While being prepared, food may become contaminated with staff hair and germs.
c. Out dated food is being used, cooked, and eaten by residents.
d. Eating contaminated and spoiled food if food is not dated or labeled.
e. If food and medication were to become contaminated.

The findings are:

Findings for food

A. On 02/07/18 at 10:26 am, during observation of the kitchen cabinet and freezer, the following foods were expired:
1. 6-5.5oz (ounce) packets of pudding cups, expiration date 10/23/17.
2. 1-8 oz container of powdered chocolate drink, expiration date of 01/2015.
3. 1-8 packet of hamburger rolls, expiration date of 01/28/2016

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 02/13/2018

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 036	Continued From page 74 4. 6-loaves of bread, expiration dates: 12/31/17, 01/01/18, 01/11/18, 01/13/18, and 2 at 01/14/18. 5. 2-french breads, expiration date 01/25/18. 6. 2-packages (12-count) of hot dog buns, expiration dated 02/01/18 and 12/31/17. 7. 1-package (7-count) of barbeque pork patties, expiration date 09/01/17. 8. The following foods items in the freezer, were not dated or labeled: a. 1-package (8-count) of french bread. b. 1-package (5-count) of cooked chicken patties. c. 1-package (10-count) of beef patties. B. On 02/07/18 at 10:40 am, during an interview with the Assistant Administrator, he confirmed that the following foods were expired: 1. 6-5.5oz (ounce) packets of pudding cups, expiration date 10/23/17. 2. 1-8 oz container of powdered chocolate drink, expiration date of 01/2015. 3. 1-8 packet of hamburger rolls, expiration date of 01/28/2016 4. 6-loaves of bread, expiration dates: 12/31/17, 01/01/18, 01/11/18, 01/13/18, and 2 at 01/14/18. 5. 2-french breads, expiration date 01/25/18. 6. 2-packages (12-count) of hot dog buns, expiration dated 02/01/18 and 12/31/17. 7. 1-package (7-count) of barbeque pork patties, expiration date 09/01/17. 8. The following foods items in the freezer, were not dated or labeled: a. 1-package (8-count) of french bread. b. 1-package (5-count) of cooked chicken patties. c. 1-package (10-count) of beef patties. Findings for medication	A 036		

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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 036	Continued From page 75 C. On 02/07/18 at 10:33 am, during observation, 1 vile of insulin/Detemir (Regular Human Insulin Injection) (Diabetes) 100 units was observed to be stored in the kitchen refrigerator with food. D. On 02/07/18 at 10:45 am, during interview with the Administrator, she confirmed that 1 vile of insulin/Detemir 100 units was observed to be stored in the kitchen refrigerator with food and she stated that the facility does not have a separate refrigerator for medications. Findings for garbage container E. On 02/07/18 at 10:51 am, during observation of the kitchen garbage container, it did not have a tight fitting lid. F. On 02/07/18 at 10:52 am, during interview with the Administrator, she confirmed that the garbage container did not have a tight fitting lid. Findings for hair nets G. On 02/08/17 at 11:00 am, during observation, DCS #4 was not wearing a hairnet while preparing and cooking food. H. On 02/08/17 at 5:00 pm, during an interview with the Administrator, she confirmed that DCS #4 was not wearing a hairnet while preparing/cooking food.	A 036		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either	A 037		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 037	Continued From page 76 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. (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	A 037		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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A 037	Continued From page 77 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/cleaning supplies were not stored in cabinets used for the storage of foods. This deficient practice could cause harm to all 16 (R #s 1-16) residents identified on the resident census provided by the Administrator on 02/07/18, by spilling cleaning supplies/chemicals on themselves or ingesting contaminated food. The findings are: A. On 02/07/18 at 10:30 am, during observation of the kitchen, the following cleaning supplies/chemicals were stored in the cabinet above the kitchen sink: 1. 1-1 gallon bottle of liquid bleach. 2. 2- 5.6 oz. cans of oven cleaner. 3. 1- 6 oz. can of insecticide. B. On 02/07/18 at 10:30 am, during an interview with the Administrator, she confirmed that the cleaning supplies/chemicals were stored in the kitchen cabinet.	A 037		
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall	A 038		

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 02/13/2018

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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 038	Continued From page 78 maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 A C Based on observation and interview the facility failed to ensure the facility's interior was cleaned as often as necessary to maintain a clean and sanitary environment in an attractive manner. This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 02/07/18, to be at risk of injury and/or illness, due to contamination from an unsafe and dirty environment. The findings are:	A 038		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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 038	Continued From page 79 Findings related to the multipurpose room A. On 02/07/18 at 11:40 am, during an observation of the multipurpose room: 1. Had 3 chairs with seating area pads that were split, the filling was bulged out, and smelled of urine. 2. The carpet was dirty with stains and smelled of urine. 3. The vent on the ceiling was covered with dust and dirt. 4. The window blinds were covered with dust and stains. B. On 02/07/18 at 11:49 am, during an interview with the Administrator, she confirmed that the multipurpose room: 1. Had 3 chairs with seating area pads that were split, the filling was bulged out, and smelled of urine. 2. The carpet was dirty with stains and smelled of urine. 3. The vent on the ceiling was covered with dust and dirt. 4. The window blinds were covered with dust and stains. Findings related to the bathrooms C. On 02/07/18 at 10:55 am, during observation of the community bathroom in between residents rooms #8 and #9, the bathroom had a strong smell of odor and that the drain on the floor was backed up. D. On 02/07/18 at 10:57 am, during interview with the Administrator, she confirmed that the community bathroom had a strong smell of odor and that the drain on the floor was backed up.	A 038		

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A 038	Continued From page 80 E. On 02/07/18 at 11:00 am, during observation of R #5's bathroom the bathroom shower had black mold around the bottom of the cubicle. F. On 02/07/18 at 11:03 am, during interview with the Administrator, she confirmed that R #5's bathroom the shower cubicle had black mold around the bottom.	A 038		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 A B Based on observation and interview the facility failed to ensure that: 1. The facility was in good repair. 2. The grounds and floors of the facility were free of safety hazards.	A 042		

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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 042	Continued From page 81 This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 02/07/18 to be at risk of being injured due to safety hazards in the back yard, the facility, and broken bathroom amenities. Finding for Amenities A. On 02/07/18 at 11:00 am, during observation of the community bathroom next to resident room #9 the fitted shower chair seat cover was split with the foam filling bulging out. B. On 02/07/18 at 11:03 am, during interview the Administrator, she confirmed that the fitted shower chair seat cover was split with the foam filling bulging out in the community bathroom next to residents room #9. C. On 02/07/18 at 11:30 am, during observation of room #7, the toilet tank was missing a cover/lid and a piece of Styrofoam was placed over the top part of the tank. D. On 02/07/18 at 11:35 am, during interview with the Administrator, she confirmed that the toilet tank was missing the lid/cover and a piece of Styrofoam was on the back of the tank. Finding for Facility Flooring E. On 02/07/18 at 11:40 am, during observation of the flooring in the multipurpose room the carpet was frayed with long fibers laying on the floor leaving small long open spaces and long loop threads. F. On 02/07/18 at 11:49 am, during an interview	A 042		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 042	Continued From page 82 with the Administrator, she confirmed that the carpet in the multipurpose room was frayed with long fibers laying on the floor leaving small long open spaces and long loop threads. Findings for the Grounds G. On 02/08/18 at 8:30 am, during observation of the grounds of the facility, there was a bed on north side of the facility outside on the sidewalk blocking the walkway and three (3) broken chairs on the south side of the facility outside on the sidewalk blocking the walkway. H. On 02/13/18 at 5:00 pm, during interview with the Administrator, she confirmed that there was a bed and three broken chairs outside the facility on the sidewalks blocking the walkways.	A 042		
A 044	7 NMAC 8.2.44 Heating, Air-Conditioning and Ventilation HEATING, AIR-CONDITIONING AND VENTILATION: A. Heating, air-conditioning, piping, boilers and ventilation equipment shall be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities shall have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility shall provide a minimum temperature of seventy (70) degrees fahrenheit, measured at three (3) feet above the floor, in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating	A 044		

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A 044	Continued From page 83 device shall be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances shall be permanently anchored and kept away from flammables such as curtains, bedcovering, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or presents danger from electrical shock. D. Fireplaces and open flame heating shall not be utilized in sleeping rooms. E. Gas fired water heaters shall not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. The facility shall be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means. G. All openings to the outside air used for ventilation shall be screened for the control of insects and rodents. Screen doors shall be equipped with self-closing devices. H. The facility shall have a system for maintaining the residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7.8.2.44 NMAC - Rp, 7.8.2.45 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.44 A G Based on record review, observation, and interview, the facility failed to ensure that: 1. The fuel fired heater and water heater of the facility was checked and tested annually by a licensed plumber or qualified personnel.	A 044		

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A 044	Continued From page 84 2. All openings/windows used for ventilation, had screens to control insects and rodents. These deficient practices could cause all 16 (R #s 1-16) residents identified on the resident census list provided by the Administrator on 02/07/18, to be at risk of injury, illness, or death by carbon monoxide positing or being infected by insect and/or rodent bites. The findings are: A. Record request for the annual fuel-fired heater/water heater inspection conducted by a licensed plumber or qualified personal revealed, that there was no documentation that any inspections had been conducted. B. On 02/07/18 at 10:15 am, during an interview with the Administrator, she confirmed that the fuel-fired heater & water heater have not been inspected annually by a licensed plumber or qualified personnel. C. On 02/07/18 at 10:40 am, during observation, there were 2 missing screens on the windows of the TV room and missing screens from the windows of resident room #s 1, 5-7, and 9. D. On 02/07/18 at 10:45 am, during an interview with the administrator, she confirmed the missing screens from the windows of resident room #s 1, 5-7, and 9 and the TV room.	A 044		
A 045	7 NMAC 8.2.45 Water WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC. A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and	A 045		

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A 045	Continued From page 85 federal laws, ordinances and regulations. B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non-community water system as defined by the current New Mexico drinking water requirements. C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented from entering potable water systems by appropriate cross connection and backflow prevention devices. D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries. E. The hot water temperature that is accessible to residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury. [7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.45 E Based on observation and interview, the facility failed to ensure that the hot water temperature that is accessible to residents is maintained between 95 -110 degrees (F) Fahrenheit. This	A 045		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 045	Continued From page 86 deficient practice could cause harm to all 16 (R #s 1-16) residents identified on the resident census provided by the Administrator on 02/07/18, if they are burned by scalding hot water. The findings are: A. On 02/07/18 at 10:40 am, during observation of the 2 resident bathrooms, the water temperature in west bathroom was 129 degrees F and the water temperature in the east bathroom was 130 degrees F. B. On 02/07/18 at 10:45 am, during an interview with the Administrator, she confirmed that the water temperatures in both bathrooms was above 110 degrees F.	A 045		
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	A 047		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 047	Continued From page 87 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 B E Based on observation and interview, the facility failed to ensure that the exit and emergency lights were in working order. This deficient practice has the potential to cause serious injury or death to all 16 (R #s 1-16) residents identified on the resident census provided by the Administrator on 02/07/18, if there were a fire, power outage, or other emergency that required evacuation. The findings are: A. On 02/07/18 at 10:50 am, during observation, the emergency light near the front office, did not work/turn on when tested. B. On 02/07/18 at 10:52 am, during observation of the 2 emergency exit signs did not work when tested. C. On 02/07/18 at 10:55 am, during interview with the Administrator, she confirmed that the emergency light by the front office and both emergency exit signs did not work/turn on when tested.	A 047		
A 048	7 NMAC 8.2.48 Electrical System	A 048		

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A 048	Continued From page 88 ELECTRICAL SYSTEM: A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility shall know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances shall be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords shall not be used. The use of a multi-socket united laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) feet in length is permitted for the intended purpose and not as an extension cord. [7.8.2.48 NMAC - Rp, 7.8.2.49 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.48 NFPA (National Fire prevention Association) 70 National Electric Code 210.8 Ground Fault Circuit Interrupter Protection for Personnel 210.8 (B) Other than dwelling units. All 125 volt, single phase, 15 and 20 ampere receptacles installed in the locations specified in 210.8 (B)(1) through (8) shall have ground fault circuit interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception 1: to (3) and (4): Receptacles that are	A 048		

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A 048	Continued From page 89 not readily accessible and are supplied by a branch circuit dedicated to electric snow melting, de-icing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22 as applicable. Exception 2: to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B) (2)shall be permitted for only those receptacles outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 6 ft. of the outside edge of the sink. Exception 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used.	A 048		

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A 048	Continued From page 90 314.25: Covers and Canopies. In completed installations, each box shall have a cover, faceplate, lampholder, or luminaire canopy, except where the installation complies with 410.24(B) 406.5(F): Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. Based on observation and interview, the facility failed to ensure that electrical outlets within 3 feet of a water supply were equipped with Ground Fault Circuit Interrupters (GFCI). This deficient practice has the potential for all 16 (R #s 1-16) residents identified by a resident census provided by the Administrator on 02/07/18, to be at risk of harm or injury from electric shock. The findings are: A. On 02/07/18 at 10:55 am, during observation, the GFCI outlet in the west side community bathroom did not turn off when tested. B. On 02/07/18 at 10:57 am, during interview with the Administrator, she confirmed the broken GFCI outlet in the west side community bathroom.	A 048		
A 055	7 NMAC 8.2.55 Toilet and Bathing Facilites TOILET AND BATHING FACILITIES: Toilet and bathing facilities shall be located appropriately to meet the needs of residents. A. A minimum of one (1) toilet, one (1) sink and one (1) bathing unit shall be provided for every eight (8) residents or fraction there of. (1) The facility shall provide at least one tub and one shower or combination unit to allow for residents bathing preference. (2) Facilities with four (4) or more residents shall	A 055		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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A 055	Continued From page 91 provide a handicap accessible bathroom for every thirty (30) residents that allows for a bathing preference. B. Facilities with four (4) or more residents must comply with accessibility requirements for the disabled. C. Toilet, sink and bathing facilities shall be readily available to the residents. No passage through a resident room by another resident to reach a toilet, bathing unit or sink facility shall be permitted. D. The combination type tub and shower shall be permitted. E. A facility with four (4) or more residents that has live-in staff shall provide a separate toilet, sink and bathing facility for staff. F. Toilets, tubs and showers shall be provided with grab bars. G. Tubs and showers shall have a slip resistant surface. H. The floors of bathrooms and bathing facilities shall have smooth, waterproof and slip-resistant surfaces. I. Toilet paper and soap shall be provided in each toilet room. J. The use of a common towel shall be prohibited. K. Bathrooms and lavatories shall be cleaned as often as necessary to maintain a clean and sanitary condition. [7.8.2.55 NMAC - Rp, 7.8.2.56 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.55 K Based on observation and interview the facility failed to ensure that the community and residents bathrooms were maintained, cleaned, sanitized,	A 055		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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A 055	Continued From page 92 and free from mold. This deficient practice has the potential to negatively affect the health and safety for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 02/07/18, if bathrooms are contaminated with germs/bacteria, and mold. The findings are: A. On 02/07/18 at 10:55 am, during observation of the community bathroom in between residents rooms #8 and #9, the bathroom had a foul smelling odor that the drain on the floor of the community bathroom was backed up. B. On 02/07/18 at 10:57 am, during interview with the Administrator, she confirmed that the community bathroom had a foul smelling odor and that the drain on the floor of the community bathroom was backed up. C. On 02/07/18 at 11:00 am, during observation of R #5's bathroom, the bathroom shower had mold around the bottom of the cubicle. D. On 02/07/18 at 11:03 am, during interview with the Administrator, she confirmed that R #5's bathroom shower cubicle had mold around the bottom.	A 055		
A 056	7 NMAC 8.2.56 Living or Multipurpose Room LIVING OR MULTIPURPOSE ROOM: The facility shall provide a minimum of forty (40) square feet per resident for common living, dining and social spaces. A. The facility shall have a living or multipurpose room for the use of the residents. Such rooms shall be provided with reading lamps, tables and chairs or couches. These furnishings shall be well constructed, comfortable and in good repair.	A 056		

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A 056	Continued From page 93 B. The living room or multipurpose rooms shall be provided with supplies to meet the varied interests and needs of the residents. C. Each activity room shall have a window area of at least one tenth (1/10) of the floor area with a minimum of at least ten (10) square feet. [7.8.2.56 NMAC - Rp, 7.8.2.57 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.56 A Based on observation and interview the facility failed to ensure that the chairs in the multipurpose room were in good repair and odor free. This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 02/07/18 to be at risk of harm or injury from sitting on broken chairs that smell of urine. The findings are: A. On 02/07/18 at 11:40 am, during observation of the chairs in the multipurpose room, 3 chairs had seating area pads that were split, the filling was bulging out, and smelled of urine. B. On 02/07/18 at 11:49 am, during an interview with the Administrator, she confirmed that the 3 chairs had seating area pads that were split. the filling bulging out, and smelled of urine in the multipurpose room.	A 056		
A 059	7 NMAC 8.2.59 Windows WINDOWS: A. Each sleeping room shall be provided with an	A 059		

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A 059	Continued From page 94 exterior window. (1) The window shall be operable, screened and have a clear operable area of 5.7 square feet minimum; measured twenty (20) inches wide minimum and measured twenty-four (24) inches high minimum. (2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor. B. Screens shall be provided on all operable windows. C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.59 A (1) B Based on observation and interview, the facility failed to ensure that all operable windows had screens on them. If the windows do not have screens, then the 16 (R #s 1-16) residents listed on the resident census, provided by the Administrator on 02/07/18 are at risk of harm if they were to fall out the window or illness from insect and/or rodent infestation/bites. The findings are: A. On 02/07/18 at 10:40 am, during observation, there were 2 missing screens on the windows in the TV room and missing screens from the windows in resident room #s 1, 5-7 and 9.	A 059		

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	5842	A. BUILDING: _____ B. WING _____	C 02/13/2018

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 059	Continued From page 95 B. On 02/07/18 at 10:45 am, during an interview with the Administrator, she confirmed the missing screens on the windows in resident room #s 1, 5-7 and 9 and the TV room.	A 059		
A 060	7 NMAC 8.2.60 Fire Clearence and Inspections FIRE CLEARANCE AND INSPECTIONS: A. Written documentation of a facility's compliance with applicable fire prevention codes shall be obtained from the state fire marshal ' s office or the fire prevention authority with jurisdiction and shall be submitted to the licensing authority prior to the issuance of an initial license. B. The facility shall request an annual fire inspection from the local fire prevention authorities. If the policy of the local fire department does not provide an annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7.8.2.60 NMAC - Rp, 7.8.2.59 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.60 B This is a repeat deficiency from a Life Safety Code Survey dated 03/30/16. Based on record review and interview, the facility failed to ensure that an annual fire inspection by the Local Fire Authority (having jurisdiction) had	A 060		

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A 060	Continued From page 96 been conducted. This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the resident census provided by the Administrator on 02/07/18, to be at risk of injury or death if a fire occurs. The findings are: A. Record request for the annual fire inspection by the Local Fire Authority revealed, no documentation of the last fire inspection completed by the Local Fire Authority. B. On 02/08/18 at 8:45 am, during an interview with the Administrator, she confirmed that they could not find the last annual fire inspection by the Local Fire Authority. She stated she requested an inspection, however, they never came out. She could not provide documentation of the the request.	A 060		
A 061	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction. B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors	A 061		

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A 061	Continued From page 97 shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service. [7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.61 A Class B Deficiency Based on observation and interview, the facility failed to ensure the fire alarm system was in good working order and not in trouble mode. If the fire alarm system is in trouble mode then it may not be reliable in notifying occupants and emergency response personnel of a potential fire in the building. This deficient practice has the potential for high risk residents, with diagnoses such as blindness and impaired ambulation (residents assisted with canes, walkers, and wheelchairs for walking/mobility) to be at risk of harm, injury, or death if a fire were to occur which resulted in a Class B deficiency being called on 02/07/18 at 1:34 pm. The Administrator was notified at this time and a Plan of Removal requested. The facility took corrective action by providing an acceptable Plan of Removal which included; "Further to the survey outcome on 02/07/2018, the facility will take the following corrective action to address the issues raised with the fire panel:	A 061		

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A 061	Continued From page 98 1. Effective 02/07/2018, a minimum of 2 employees will be in attendance at all shifts. 2. A call has been placed on 02/07/2018 with [name of company] fire panel company to inspect and fix the panel defect on 02/08/18. 3. Effective 02/07/2018 the facility will provide fire watch cover on 24-hour basis until the fire panel is resolved." On 02/07/18 at 3:00 pm, the Plan of Removal was accepted. The Administrator was notified at this time that the Class B Deficiency was lifted. Based on record review, observation, and interview, the facility failed to ensure the fire alarm system is in good working order and not in trouble mode. This deficient practice presents a potential risk to all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 02/07/18, and all occupants in the building to be at risk of harm, injury, or death if the fire alarm system is not in working order and does not alert residents and occupants if a fire were to occur. The findings are: A. On 02/06/18 at 9:15 pm, during observation and tour of the facility, it was observed that the fire alarm panel was in trouble mode. B. On 02/06/18 at 9:38 pm, during an interview with the Administrator, she confirmed that the fire panel was in trouble mode.	A 061		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction.	A 063		

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A 063	Continued From page 99 A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B NFPA (National Fire Prevention Association) 10, Standard for Portable Fire Extinguishers, 2010 Edition: 6.1.3 Placement. 6.1.3.1 Fire extinguishers shall be conspicuously located where they are readily accessible and immediately available in the event of fire. 6.1.3.2 Fire extinguishers shall be located along normal paths of travel, including exits from areas. 7.2 Inspection. 7.2.1 Frequency. 7.2.1.1* Fire extinguishers shall be manually inspected when initially placed in service. 7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic	A 063		

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A 063	Continued From page 100 monitoring device/system at a minimum of 30-day intervals. 4-3 Inspection. Based on observation and interview, the facility failed to ensure that all portable fire extinguishers were maintained in accordance with NFPA 10 Standard for Portable Fire Extinguishers and inspected monthly. This deficient practice could cause harm to all 16 (R #s 1-16) residents identified on the resident census provided by the Administrator on 02/07/18, by not having a working fire extinguisher in the event of a fire. The findings are: A. On 02/06/18 at 9:38 pm, during observation of the 4 facility fire extinguishers it was observed that: 1. The inspection tags for the fire extinguishers were not signed as inspected monthly in the entire year of 2017 or in January and February of 2018. 2. The fire extinguisher next to the office was showing it was not charged. B. On 02/06/18 at 9:40 pm, during an interview with the Administrator, she confirmed that the 4 fire extinguishers were not being inspected each month and that the fire extinguisher next to the office was empty and had no charge in it.	A 063		
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	A 070		

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A 070	Continued From page 101 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: 7.8.2.70 D E F This is a repeat deficiency from survey dated 02/06/13 Based on record review and interview the facility failed to ensure: 1. Employee Abuse Registry (EAR) enquiry was submitted prior-to-hire. 2. The application and fingerprints for the Caregiver Criminal History Screening program (CCHSP) were submitted within 20 days of the date of hire. 3. Incidents of suspected or known resident abuse, neglect, or unusual occurrence are reported to the Licensing Authority. This deficient practice has the potential for all 16 (R #s 1-16) residents identified on the census provided by the Administrator on 02/07/18, to be at risk of being provided care by staff who may have a previous history of abusing, neglecting, or	A 070		

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A 070	Continued From page 102 exploiting residents and/or is a convicted felon and if there is no over-site of the care and services the facility is providing. Findings for EAR/CCHSPs: A. Record review of DCS #1's (hire date: 02/09/16) employee file revealed, that the EAR clearance application was not submitted/clearance received until 02/12/16, after the date of hire. There was no documentation that the fingerprints were submitted to the CCHSP within 20 days of hire or clearance letter in the file. B. Record review of DCS #2's (hire date: 08/23/17) employee file revealed, that the EAR application was not submitted/clearance received until 12/05/17, after date of hire. C. On 02/08/18 at 9:30 am, during an interview with the Administrator, she confirmed that the EAR applications were not submitted/clearances received for DCS #s 1 and 2 prior to hire. She also confirmed that there was no documentation in DCS #1's employee file that the fingerprints were submitted to or clearance letter received from the CCHSP. Findings for Incident Reporting: D. Record review of facility's internal incidents reports revealed the following: 1. R #6's incident report dated 08/01/17, stated on [redacted]/17 that resident had fell against wall hurting [redacted] face and then again on [redacted]/17, [redacted] fell to the floor in [redacted] room, hurting [redacted] left knee, complained abut being sore, and had a small cut over [redacted] right eye. Resident was taken to a medical facility.	A 070		

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A 070	Continued From page 103 2. R #7's incident report dated 01/10/18, stated that resident had an unwitnessed fall with injury of unknown source, was found sleeping on the floor. DCS #5 woke [redacted] up and helped [redacted] back into bed. DCS #5 woke resident up at 7:30 am resident had two bumps on [redacted] forehead. 3. R #8's incident report dated 07/26/17, states that resident got upset with another resident because [redacted] asked for [redacted] plate to clear from the table. R #8 left dining room and was yelling and throwing things. [redacted] continued to [redacted] room and threw all [redacted] belongings into the hallway. After that, [redacted] continued outside where [redacted] threw chairs, garbage can, glass bottles, rocks and chip bags into the parking area. [redacted] then left the facility. 4. R #9's incident report dated 04/03/17, states that resident went into the bathroom and tripped over [redacted] feet. [redacted] fell in front of the first stall. Landed on [redacted] right side. staff member helped resident up. Resident stated [redacted] was fine and went back to [redacted] room. A few minutes later resident complained that [redacted] shoulder was hurt. Resident was taken to emergency room. 5. R #10's incident report dated 08/07/17, stated that on 08/05/17 residents were in the living room and started yelling. R #10 was yelling another person went into the living room to see what was happening and R #10 began yelling at [redacted] Both residents went into the hallway and picked up the mop while yelling at each other. The mop dropped and both residents went back to their rooms. The [redacted] resident in the living room showed staff member [redacted] left leg which had a bruise developing. Resident stated that R #10 threw [redacted] The police were called. E. On 02/08/18 at 0:55 am, during an interview with the Administrator, she confirmed that the	A 070		

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A 070	Continued From page 104 above incidents for R #s 6-10 were not reported to the Licensing Authority. She also confirmed that no 5 day follow-up investigation reports were completed and/or submitted to the Licensing Authority.	A 070		