STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5533	A. BUILDING: _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY HOME INC	802 EAST HILL STREET GALLUP, NM 87301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited as a result of a Full-Onsite/Complaint survey completed on 02/15/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake NM#30458 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: 7.8.2.16 B (3) (9) 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 making the inquiry to the registry prior to	A 016		

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A 016	Continued From page 3	A 016		

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 directed plan of correction, civil monetary penalty

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A 016	Continued From page 4 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 rules. The fees will not be applied to any other	A 016		

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A 016	Continued From page 5 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 the care provider.	A 016		

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A 016	Continued From page 6 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 6 (R #s 1-6)residents on the census provided by the Administrator on 02/07/18, being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents or have a felony conviction. The findings are:	A 016		

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A 016	Continued From page 7 A. Record review of Direct Care Staff (DCS #1's) employee file (hire date 01/15/18) revealed, the EAR clearance was not submitted until 01/16/18. B. Record review of DCS #2's employee file (hire date 11/30/15) revealed, the EAR clearance was not submitted until 02/29/16 and fingerprints dated 03/17/16 were not submitted within 20 days of hire. C. On 02/15/18 at 11:45 am, during an interview with the Administrator, she confirmed that the DCS #s 1 and 2 EAR clearances were not received prior to hire and DCS #2's fingerprints were not submitted within 20 days of hire.	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: (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;	A 017		

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A 017	Continued From page 8 (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 (1-2) (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 trainings and could provide the supporting documentation for: 1. 16-hours of providing supervised care, prior to providing unsupervised care for the residents 2. 12-hours of the required orientation and annual trainings in: b. First aid. c. Safe food handling practices to include: i. Instructions in proper storage.	A 017		

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A 017	Continued From page 9 ii. Preparation and serving of food. iii. Safety in food handling. iv. Appropriate personal hygiene. v. Infectious and communicable disease control. d. Confidentiality of records and resident information. e. Infection control. f. Resident rights. g. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. h. Smoking policy for staff, residents and visitors. i. Methods to provide quality resident care. j. Emergency procedures. k. Medication assistance, including the certificate of training for staff that assist with medication delivery. l. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs. This deficient practice has the potential for all 6 (R #s 1-6) 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 01/15/18) employee file revealed: 1. No documentation that DCS #1 completed the 16-hours of providing supervised care, prior to providing unsupervised care for the residents. 2. The orientation/annual training form (dated 01/14/18) revealed, that it does not contain the signature of DCS #1 confirming that she had completed the trainings.	A 017		

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A 017	Continued From page 10 3. No documentation confirming that DCS #1 completed the following trainings at orientation: a. Fire safety and evacuation training. b. First aid. c. 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 disease control. d. Confidentiality of records and resident information. e. Infection control. f. Resident rights. g. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. h. Smoking policy for staff, residents and visitors. i. Methods to provide quality resident care. j. Emergency procedures. k. Medication assistance, including the certificate of training for staff that assist with medication delivery. l. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs. B. Record review of DCS #2 (date of hire: 11/30/15) employee file revealed: 1. No documentation that DCS #2 completed the 16-hours of providing supervised care, prior to providing unsupervised care for the residents. 2. The orientation/annual training form (dated 12/02/15) revealed, that it does not contain the signature of DCS #2 confirming that she had completed the trainings.	A 017		

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A 017	Continued From page 11 3. No documentation confirming that DCS #2 completed the following trainings at orientation: a. Fire safety and evacuation training. b. First aid. c. 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 disease control. d. Confidentiality of records and resident information. e. Infection control. f. Resident rights. g. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. h. Smoking policy for staff, residents and visitors. i. Methods to provide quality resident care. j. Emergency procedures. k. Medication assistance, including the certificate of training for staff that assist with medication delivery. l. The proper way to implement a resident ISP for staff that assist with ISPs. 4. No documentation confirming that DCS #2 completed the following annual trainings: 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	A 017		

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A 017	Continued From page 12 visitors. g. Methods to provide quality resident care. h. Emergency procedures. i. The proper way to implement a resident ISP for staff that assist with ISPs. C. On 02/15/18 at 11:45 am, during an interview with the Administrator, she confirmed for DCS #s 1 & 2 that: 1. There was no documentation that they had completed 16-hours of of providing supervised care, prior to providing unsupervised care for the residents. 2. Neither DCS had signed the orientation/annual training forms stating they had received the required trainings. 3. She could not confirm if the trainings listed above had actually taken place.	A 017		
A 018	7 NMAC 8.2.18 Policies POLICIES: The facility shall have and implement written personnel policies for the following: A. staff, private duty attendant and volunteer qualifications; B. staff, private duty attendant and volunteer conduct; C. staff, private duty attendant and volunteer training policies; D. staff and private duty attendant and volunteer criminal history screening; E. emergency procedures; F. medication administration; G. the retention and maintenance of current and past personnel records; and H. facilities shall maintain records and files that reflect compliance with NM and federal employment rules.	A 018		

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A 018	Continued From page 13 [7.8.2.18 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]	A 018		

This REQUIREMENT is not met as evidenced by:
7.8.2.18 C E F G

Based on record review and interview, the facility failed to have written personnel policies for the following:
1. Staff, private duty attendant, and volunteer training policies.
2. Emergency procedures.
3. Medication administration.
4. Retention and maintenance of personnel records.
This deficient practice could cause harm to all 6 (R #s 1-6) residents, identified on the census provided by Administrator on 02/07/18, by having staff not trained or aware of the correct way to implement facility policy and procedures that affect the safety and welfare of the residents. The findings are:

A. Record review of the facility's Policy and Procedure manual revealed, that the following required policies and procedures were missing:
1. Staff, private duty attendant and volunteer training policies.
2. Emergency procedures.
3. Medication administration.
4. The retention and maintenance of current and past personnel records.

B. On 02/14/18 at 10:15 am, during an interview with the DCS #1, she confirmed the missing policies from their facility policy & procedure

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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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 018	Continued From page 14 manual.	A 018		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (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	A 020		

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	5533	A. BUILDING: _____ B. WING _____	C 02/15/2018

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A 020	Continued From page 15	A 020		

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

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A 020	Continued From page 16 (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in 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	A 020		

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A 020	Continued From page 17 needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (2) (3) (5) (8) (9-11) (12) (a-d) (13)	A 020		

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A 020	Continued From page 18 Based on record review and interview, the facility failed to ensure for 3 (R #s 1-3) of 3 (R #s 1-3) residents, whose admission agreements were reviewed for compliance were accurate and compete and included the following required information: 1. Facility narrative. 2. Facility rules. 2. Refund policy for death, transfer, voluntary or involuntary discharge. 3. Facility staffing ratio. 4. Written authorization for staff to assist with self-administration of medications. 5. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements. 6. Bed hold policy. 7. The admissions 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. Residents health improves. 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 services the facility will provide. 2. Not knowing the rules of the facility to abide by. 3. Resident's estate or responsible party unaware of any refund that may be due. 4. Being misinformed regarding the number of direct care staff that will be available to assist	A 020		

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residents on each shift.

5. Being misinformed about the direct care staff ability to administer medications.

6. 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.

7. Unaware of the facility's bed-hold policy and the additional financial responsibilities associated.

8. Being discharged before an appropriate placement was found.

9. Being charged for new/changed care services without the appropriate 30-day notice

The findings are:

A. Record review of R# 1's admission agreement (dated 12/23/10), revealed it was missing the following information:

1. Facility's narrative.

2. Facility's rules.

3. 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 admissions 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. Residents health improves.

8. Facility shall provide a thirty (30) day

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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 04/21/15), revealed it was missing the following information: 1. Refund policy for death, transfer, voluntary or involuntary discharge. 2. Facility staffing ratio. 3. Written authorization for staff to assist with medications. 4. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements. 5. The admissions 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. Residents health improves. e. Termination without prior notice for emergency situations; 6. 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 (dated 10/16/10), revealed it was missing the following information: 1. Refund policy for death, transfer, voluntary or involuntary discharge. 2. Facility's staffing ratio. 3. The admissions agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances:	A 020		

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A 020	Continued From page 21 a. There shall be a fifteen (15) day written notice of termination given. b. Resident fail to pay. c. Facility fail to operate. d. Residents health improves. 4. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. D. On 02/15/18 at 11:45 am, during an interview with the Administrator, she confirmed that the above findings were missing from R #s 1-3 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 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	A 021		

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A 021	Continued From page 22 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; (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	A 021		

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A 021	Continued From page 23 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 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.	A 021		

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A 021	Continued From page 24 (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) (2) (3) (4) B (1) (2) Based on record review and interview, the facility failed to maintain their resident records in an organized manner so that they are readily available to assist staff with the care of the 3 (R #s 1-3) of 3 (R #s 1-3) residents sampled for compliance. This deficient practice could cause harm to the residents, identified on the resident census provided by the Administrator on 02/07/18, by not having current and accurate information that is organized, so that it is readily available for staff to review when they need information on providing care to the residents. The findings are: Finding related to admission agreements A. Record review of R #1's Admission Agreement (dated 12/23/10) revealed, it was missing the following required information: 1. The program narrative. 2. The facility's rules. 3. The refund provision in case of death. 4. Information on advance directives. 5. A written description of the residents legal rights. 6. Staffing ratio's. 7. Written authorization for staff to assist with	A 021		

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medications.
8. The rights and responsibilities pursuant to the incident reporting intake, processing and training requirements.
9. The bed hold policy.
10. Termination if an appropriate placement is found.

B. Record review of R #2's Admission Agreement (dated 02/12/14) revealed, it was missing the following required information:
1. The refund provision in case of death.
2. Information on advance directives.
3. Staffing ratio's.
4. Written authorization for staff to assist with medications.
5. The rights and responsibilities pursuant to the incident reporting intake, processing and training requirements.
6. Termination if an appropriate placement is found.

C. Record review of R #3's Admission Agreement (dated 10/15/10) revealed, it was missing the following required information as required by the licensing authority;
1. The program narrative.
2. The refund provision in case of death.
3. Information on advance directives.
4. Staffing ratio's.
5. The rights and responsibilities pursuant to the incident reporting intake, processing and training requirements.
6. Termination if an appropriate placement is found.

Findings related to resident evaluations

D. Record review of R #1's evaluation (dated 02/05/18) revealed:

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A 021	Continued From page 26 1. No documentation listed for last visit to the eye doctor and/or dentist. 2. R #1's current evaluation was dated 02/05/18 and the prior evaluation was dated 03/06/17, 11 months between reviews. 3. R #1's evaluation was missing the signature page to show if a nurse, physician, or physician extender reviewed the evaluation for accuracy. E. Record review of R #2's evaluation (dated 02/05/18) revealed: 1. No documentation listed for last visit to the eye doctor, and/or dentist. 2. R #2's current evaluation was dated 02/05/18 and the prior evaluation was dated 03/06/17, 11 months between reviews. 3. R #2's evaluation was not signed as reviewed by a nurse, only the Administrator signed evaluation on 02/05/18. F. Record review of R #3's evaluation dated (02/05/18) revealed; 1. No documentation listed for last visit to the eye doctor or dentist. 2. R #3's current evaluation was dated 02/05/18 and the prior evaluation was dated 03/06/17, 11 months between reviews. 3. R #3's evaluation was not signed as reviewed by a nurse, only the Administrator signed evaluation on 02/05/18. G. On 02/15/18 at 1:35 pm, during an interview with the Administrator, she confirmed the missing documentation in R #s 1-3s resident evaluations. The Administrator also confirmed the the evaluations were not reviewed by a nurse. Findings related to the Resident's Individual Service Plan (ISP)	A 021		

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A 021	Continued From page 27 H. Record review of R #1's resident file revealed, there was no ISP in R #1's resident file. I. Record review of R #2's ISP (dated 04/20/17) revealed: 1. The ISP did not address all areas of need, identified in R #2's evaluation including: a. Problems hearing. b. Complains of pain and how it will be controlled. c. Unable to self-administer their own medication. 2. The ISP does not detail the services provided by the facility: a. Seizure disorder, the services provided section says "administer medication as ordered, nothing in ISP or his facility record states what staff should due in the event of a seizure. b. Depression, the services provided section says, "avoid unnecessary stimulation", but does not tell staff how or what to avoid. c. Hyperextreme anxiety, the services provided sections says "describe completely any procedure or doctor orders and activities", which does not make any sense. 3. The ISP with the last review date of 04/20/17, was not reviewed by a licensed practical nurse, registered nurse or a physician extender and it read no changes as the only entry. 4. The ISP was not 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: a. The last review of R #2's ISP was dated 04/20/17, 10 months and 6 days late. b. The previous ISP was dated 08/19/15, 1 year, 8 months and 1 day between reviews. 5. The ISP does not describe how the	A 021		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY HOME INC	802 EAST HILL STREET GALLUP, NM 87301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 021	Continued From page 28 services will by provided, it just reads, "daily". J. Record review of R #3's resident file revealed, there was no ISP in R #3's resident file. K. On 02/15/18 at 1:35 pm, during an interview with the Administrator, she confirmed the ISP findings for R #2 and that there was no current ISP in either R #1's or R #3's file. In addition the Administrator confirmed the errors in the admissions agreements, evaluations, R #2's ISP, and that there was no current ISP in either R #1's or R #3's file.	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 applicable, municipal, or federal laws and regulations and pursuant to Subsection B of	A 022		

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A 022	Continued From page 29 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. B. Reports and records. Each facility shall keep the following reports, records, policies and	A 022		

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A 022	Continued From page 30	A 022		

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 PCP orders, treatments and diet plans every six (6) months or when a significant change occurs,

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A 022	Continued From page 31 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 assistance to residents with boarding or alighting from motor vehicles and safe operation of motor	A 022		

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A 022	Continued From page 32 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 6 (R #s 1-6) 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. b. Power failure, fire or natural disaster. i. Plans shall include evacuation	A 022		

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A 022	Continued From page 33 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. revealed that there wasn't any, 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 Resident files, (R #'s 2 & 3) there was a copy of house rules, 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 consolidating the residents current physician or PCP orders, treatments and diet plans every six	A 022		

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A 022	Continued From page 34 (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. Smoking policy for staff, residents and visitors. (does not state where designated area is & no mention of an approved, non-combustible ashtray) 6. Staff training appropriate to staff responsibilities. 7. Mealtimes, daily snacks, menus, special diets, resident's personal preference for eating alone or in the dining room setting. D. On 02/15/18 at 8:45 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:	A 025		

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A 025	Continued From page 35 (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (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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A 025	Continued From page 36 This REQUIREMENT is not met as evidenced by: 7.8.2.25 C (4) (13) E Based on record review and interview, the facility failed to ensure for 3 (R #s 1-3) of 3 (R #s 1-3) residents whose evaluations were reviewed for compliance that: 1. The resident evaluation addressed vision, and dental needs. 2. The evaluation was updated and reviewed by a Licensed Nurse (LN) and/ or a Physician Extender (PE) every 6 months or when a change of condition had occurred. These deficient practices have the potential for residents to be harmed if they do not receive the care and services they need, if the Direct Care Staff do not know what care and services are needed, and/or when a change of condition has occurred. The finding are: D. Record review of R #1's evaluation (dated 02/05/18) revealed: 1. No documentation listed for last visit to the eye doctor and/or dentist. 2. R #1's current evaluation was dated 02/05/18 and the prior evaluation was dated 03/06/17, 11 months between reviews. 3. R #1's evaluation was missing the signature page to show if a nurse, physician, or physician extender reviewed the evaluation for accuracy. E. Record review of R #2's evaluation (dated 02/05/18) revealed:	A 025		

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A 025	Continued From page 37 1. No documentation listed for last visit to the eye doctor, and/or dentist. 2. R #2's current evaluation was dated 02/05/18 and the prior evaluation was dated 03/06/17, 11 months between reviews. 3. R #2's evaluation was not signed as reviewed by a nurse, only the Administrator signed evaluation on 02/05/18. F. Record review of R #3's evaluation dated (02/05/18) revealed; 1. No documentation listed for last visit to the eye doctor or dentist. 2. R #3's current evaluation was dated 02/05/18 and the prior evaluation was dated 03/06/17, 11 months between reviews. 3. R #3's evaluation was not signed as reviewed by a nurse, only the Administrator signed evaluation on 02/05/18. G. On 02/15/18 at 1:35 pm, during an interview with the Administrator, she confirmed the missing documentation in R #s 1-3s resident evaluations. The Administrator also confirmed the the evaluations were not reviewed by a nurse.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan 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	A 026		

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A 026	Continued From page 38 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, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (1-3) B (1-10) Based on record review and interview, the facility failed to ensure for 3 (R #s 1-3) of 3 (R #s 1-3) residents whose Individual Service Plans (ISPs) were reviewed for compliance:	A 026		

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A 026	Continued From page 39 1. There was an ISP on file and available for review. 2. That all areas of need identified in the evaluations were addressed in the ISP. 3. That the ISP was reviewed at a minimum of every 6 months or when a change in condition occurred. These deficient practices can cause harm to the residents if they do not received the individual care and services needed because the Direct Care Staff (DCS) do not know what the needs of the are because: 1. There is not an ISP available for review. 2. The ISPs do not address all the residents needs identified in the the evaluation. 3. The ISP are not updated every 6 mouths or when a change of condition occurs. The findings are: A. Record review of R #1's resident file revealed, there was no ISP in R #1's residential file. B. Record review of R #2's ISP (dated 04/20/17) revealed: 1. The ISP did not address all areas of need, identified in R #2's evaluation including: a. Problems hearing. b. Complains of pain and how it will be controlled. c. Unable to self-administer their own medication. 2. The ISP does not detail the services provided by the facility: a. Seizure disorder, the services provided section says "administer medication as ordered, nothing in ISP or his facility record states what staff should due in the event of a seizure. b. Depression, the services provided section says, "avoid unnecessary stimulation", but	A 026		

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A 026	Continued From page 40 does not tell staff how or what to avoid. c. Hyperextreme anxiety, the services provided sections says "describe completely any procedure or doctor orders and activities", which does not make any sense. 3. The ISP with the last review date of 04/20/17, was not reviewed by a licensed practical nurse, registered nurse or a physician extender and it read no changes as the only entry. 4. The ISP was not 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: a. The last review of R #2's ISP was dated 04/20/17, 10 months and 6 days late. b. The previous ISP was dated 08/19/15, 1 year, 8 months and 1 day between reviews. 5. The ISP does not describe how the services will by provided, it just reads, "daily". C. Record review of R #3 's resident file revealed, there was no ISP in R #3's residential file. D. On 02/15/18 at 1:35 pm, during an interview with the Administrator, she confirmed the ISP findings for R #2 and that there was no current ISP in either R #1's or R #3's file.	A 026		
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	A 033		

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A 033	Continued From page 41 meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (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	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5533	A. BUILDING: _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY HOME INC	802 EAST HILL STREET GALLUP, NM 87301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 42 medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely 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;	A 033		

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A 033	Continued From page 43 (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [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 (4) (5) (11) (j) Based on observation and interview, the facility failed: 1. To provide a safe and sanitary living environment. 2. To provide humane care by serving expired food.	A 033		

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A 033	Continued From page 44 3. To protect residents rights by having them or their decision makers participate in the development of their Individual Service Plan (ISP). This deficient practice can cause harm to all 6 (R #s 1-6) residents, as identified on the census list provided by the Administrator on 02/07/18, if the: 1. Environment is not safe and/or clean. 2. Food is old and/or contains germs/bacteria. 3. Residents/Decision makers do not participate in the development of their ISPs. The findings are: Findings related to water leak in wall A. On 02/15/18 at 8:05 am, during an observation of the wall and floor on the lower level, water was flowing out of the lower part of the wall onto the floor. B. On 02/15/18 at 8:10 am, during an interview with Direct Care Staff (DCS #3), she confirmed that water was flowing out of the lower part of the wall onto the floor and stated that it always happens after the rain or snow. Findings related to expired foods C. On 02/14/18 at 9:50 am, during an observation of the kitchen pantry revealed: 1.) 1 loaf of bread dated 01/02/18. 2.) 3-13 ounce (oz) jars of chocolate spread all have an expiration date of 08/20/15. 3.) 2-16 oz baking mix that had an expiration date of 10/06/17. 4.) 1-13.5 oz packet of crackers expiration date 07/20/17. 5.) 114 oz packet of bread stuffing mix	A 033		

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A 033	Continued From page 45 expiration date 11/18/16. D. On 02/14/18 at 9:55 am, during an interview with DCS #3, she confirmed the findings that the food listed above stored in the refrigerator and the kitchen cabinet was expired. Findings related to ISPs E. Record review of R #s 1-3 ISPs revealed, that none of the residents/decision makers participated in the development of their ISPs. F. Record review of the resident files for R #s 1 & 3, revealed that there was no current ISP in their file! F. On 02/15/18 at 1:35 pm, during an interview with the Administrator, she confirmed that the residents do not participate in the development of their ISP's and that the ISPs for R #s 1 & 3 were missing from their resident files.	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.	A 034		

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A 034	Continued From page 46 (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (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;	A 034		

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A 034	Continued From page 47 (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects 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	A 034		

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A 034	Continued From page 48 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 record review, observation, and interview, the facility failed to: 1. Renew their Custodial Drug Permit. 2. Have a separate locked refrigerator for medications that require refrigeration. These deficient practices can harm all 6 (R #s 1-6) residents, as identified on the census list provided by the Administrator on 02/07/18, if: 1. They do not have a current Custodial Drug Permit as required by regulation. 2. There is not a separate medication refrigerator to store and protect resident medications. The findings are: A. Record review of the facilities Custodial Drug Permit, revealed it expired on 12/31/17, 45 days past expiration. B. On 02/14/18 at 10:35, during an observation, there was no separate refrigerator to store any medications that require refrigeration. C. On 02/15/18 at 1:35 pm, during an interview with the Administrator, she confirmed the Custodial Drug Permit expired and there was no medication refrigerator.	A 034		

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A 035	Continued From page 49	A 035		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the 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	A 035		

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A 035	Continued From page 50 PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug 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	A 035		

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A 035	Continued From page 51 to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. 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:	A 035		

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A 035	Continued From page 52 (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (2) (4-6) (12) (16) (17) Based on record review and interview, the facility failed to ensure that: for 3 (R #s 1-3) of 3 (R #s 1-3) residents whose Medication Administration Records (MARs) were reviewed for compliance included the following required information: 1. Any known allergies to medications. 2. The diagnosis or the reason for the medication. 3. Both the brand/generic names of the medication. 4. Notation the medication is a schedule II-IV drug (controlled).	A 035		

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A 035	Continued From page 53 5. The start and end date of the medication. 6. The desired results obtained from or problems encountered with the medication. 7. The initials and signature of the person assisting with medication. If the MARs do not include all the required information, then residents may be at risk of harm or illness and need medical treatment, if medication errors occur because vital information is missing. The findings are: A. Record review of R #1's [redacted]/18 to [redacted]/18 MAR, revealed missing information for: [redacted]	A 035		

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A 035	Continued From page 54 (supplement) B. Record review of R #2's [redacted]/18 - [redacted]/18 MAR, revealed missing information for: [redacted] C. Record review of R #3's [redacted]/18 - [redacted]/18 MAR, revealed missing information for: [redacted]	A 035		

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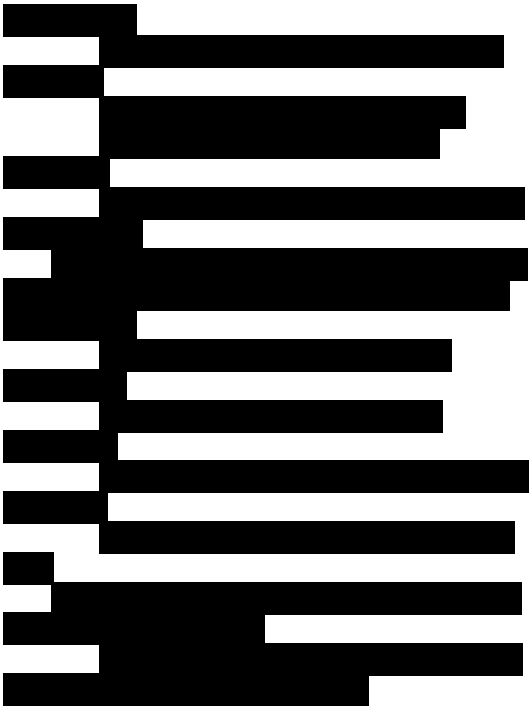
A 035	Continued From page 55	A 035		



D. On 02/15/18 at 11:45 am, during an interview with the Administrator, she confirmed the above findings for the missing information on the MARs dated 02/01/18 - 02/14/18 for R #s1-3.

A 036 7 NMAC 8.2.36 Nutrition

A 036

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

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	5533	A. BUILDING: _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY HOME INC	802 EAST HILL STREET GALLUP, NM 87301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 036	Continued From page 56 accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special 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	A 036		

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A 036	Continued From page 57 eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the 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	A 036		

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A 036	Continued From page 58 protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting 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,	A 036		

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A 036	Continued From page 59 prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is 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	A 036		

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A 036	Continued From page 60 regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal 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]	A 036		

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A 036	Continued From page 61 This REQUIREMENT is not met as evidenced by: 7.8.2.36 D Based on observation and interview, the facility failed to ensure that food being stored and used at for meals was not passed its expiration date. This deficient practice has the potential to negatively affect the health and safety of all 6 (R #s 1-6) residents identified on census provided by the Administrator on 02/07/18, to be at risk of contracting foodborne illnesses if out dated food is being used, cooked, and eaten by residents. The findings are: A. On 02/14/18 at 9:50 am, during an observation of the kitchen pantry revealed: 1.) 1 loaf of bread dated 01/02/18. 2.) 3-13 ounce (oz) jars of chocolate spread all have an expiration date of 08/20/15. 3.) 2-16 oz baking mix had an expiration date of 10/06/17. 4.) 1-13.5 oz packet of crackers expiration date 07/20/17. 5.) 114 oz packet of bread stuffing mix expiration date 11/18/16. B. On 02/14/18 at 9:55 am, during an interview with Direct Care Staff (DCS #3), she confirmed the findings that the food listed above stored in the refrigerator and the kitchen cabinet was expired.	A 036		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall	A 037		

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A 037	Continued From page 62 provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (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	A 037		

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A 037	Continued From page 63 storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (2) (3) (10) Based on observation and interview, the facility failed to ensure cleaning supplies were kept in a secured room or closet. The deficient practice has the potential for all 6 (R #s 1-6) residents identified on the resident census provided by the Administrator on 02/07/18, to be at risk of harm or injury if they were to ingest or spill cleaning supplies on their face or body. The findings are: A. On 02/14/18 at 10:15 am, during an observation of the hallway cupboard, cleaning supplies were being stored unsecured and accessible to residents as follows: 1. 2-1 gallon bottle of bleach. 2. 1-18 fl oz. dish soap. 3. 1-28 oz container of multipurpose cleaner. B. On 02/14/18 at 11:45 am, during interview with the Administrator, she confirmed the above findings cleaning supplies were stored in an unlocked cupboard.	A 037		
A 041	7 NMAC 8.2.41 Building Construction BUILDING CONSTRUCTION: All building	A 041		

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A 041	Continued From page 64 construction shall be based upon the facility occupancy in accordance with the state building code and fire codes, pursuant to 14.7 NMAC. A. New facilities. All new facilities, relocated into existing building(s) or remodeled facilities shall conform to the current edition of the state building code, accessibility code, mechanical code, plumbing code, fire code and the electrical code. (1) With regard to building height, allowable area or construction type, the state building code shall prevail. (2) Minimum construction requirements shall comply with all applicable state building codes. (3) A facility may share a building with another health care facility licensed by the department or other suitable facility with prior approval from the licensing authority. (4) Where there are conflicts between the requirements in the codes and the provisions of this rule, the most restrictive condition shall apply. B. Access for persons with disabilities. Facilities with four (4) or more residents shall provide accessibility to residents with disabilities in accordance with the state building code and the American Disabilities Act. Areas of specific concern are as follows: (1) the main entry into the facility and all required exits shall provide access to persons with disabilities; (2) the building shall allow access to persons with disabilities to all common areas; (3) at least one bedroom, for every eight (8) residents, shall have a door clearance of thirty-six (36) inches for access by persons with disabilities; (4) at least one toilet and bathing facility, for every eight (8) residents, shall have a minimum door clearance of thirty-six (36) inches for access by persons with disabilities; this toilet and bathing	A 041		

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A 041	Continued From page 65	A 041		

room shall provide a minimum sixty (60) inch diameter clear space to accommodate the turning radius of a wheelchair;
(5) when ramps are used, each ramp shall have a minimum slope of twelve (12) inches horizontal run for each one (1) inch of vertical rise; ramps exceeding a six (6) inch rise shall be provided with handrails on both sides of the ramp;
(6) landings at doorways shall have a level area, at a minimum of five (5) feet by five (5) feet, to provide clear space for wheelchair maneuvering;
(7) parking spaces shall provide access aisles with a minimum width of sixty (60) inches and ninety-six (96) inches for van parking; a minimum of one (1) van-accessible parking space with a minimum width of ninety-six (96) inches shall be provided;
(8) an accessible route for persons with disabilities from the parking area to the main entrance(s) shall be provided; and
(9) changes in elevation of one half inch (1/2 inch) or greater shall be sloped to a minimum of twelve (12) inches horizontal run for each one (1) inch of vertical rise.
C. Construction drawings. Prior to commencement of all new construction, remodeling, relocations, additions or renovations to existing buildings; the facility shall submit preliminary plans and final construction drawings with specifications to the licensing authority for review and approval.
(1) Building plans and specifications shall be submitted and approved by the department when:
(a) construction for a new facility is proposed;
(b) a building that has not previously licensed as a facility is proposed as a location for a facility;
(c) any renovation that increases the number of beds is proposed;
(d) any addition to an existing structure is

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A 041	Continued From page 66 proposed; or (e) any renovation to the existing structure is proposed, regardless of the size of the facility. (2) The codes that are in effect at the time of the submittal of building plans shall be the codes used through the end of the project. (3) Drawings and specifications shall be prepared for the architectural, structural, mechanical and electrical branches of work for each construction project and shall include the following: (a) the site plan(s) showing property lines, finish grade, location of existing and proposed structures, roadways, walks, utilities and parking areas; (b) the floor plan(s) showing scale drawings of typical and special rooms, indicating all fixed and movable equipment and major items of furniture; (c) the separate life safety plans showing the fire and smoke compartment(s), all means of egress and exit markings, exits and travel distances, dimensions of compartments and calculation and tabulation of exit units, all fire and smoke walls shall be graphically coded; (d) the exterior elevation of each facade; (e) the typical sections throughout the building; (f) the schedule of finishes; (g) the schedule of doors and windows; (h) the roof plans; and (i) the building code analysis. (4) For facilities with more than fifteen (15) residents: architectural drawings shall be stamped, signed and dated by a licensed architect registered in New Mexico. In addition to items listed in section (3) above, the drawings shall include the following: (a) the building code analysis; and (b) when an elevator is required, the details and dimensions of the elevator. (5) Structural drawings shall include the following:	A 041		

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A 041	Continued From page 67 (a) a certification that all structural design and work are in compliance with all applicable local codes; (b) the plans of foundations, floors, roofs and intermediate levels that show a complete design with sizes, sections and the relative location of the various members; and (c) the schedules of beams, girders and columns. (6) Mechanical drawings shall include the following: (a) a certification that all mechanical work and equipment are in compliance with all applicable local codes and laws and that all materials are listed by recognized testing laboratories; (b) the water supply, sewage and heating, ventilation and air conditioning piping systems; (c) the heating, ventilating, HVAC piping and air conditioning systems with all related piping and auxiliaries, if any, to provide a satisfactory installation; (d) the water supply, sewage and drainage with all lines, risers, catch-basins, manholes and cleanouts clearly indicated as to location, size, capacities and location and dimensions of septic tank and disposal field; (e) the sprinkler head layout; and (f) the graphic coding (with a legend) to show supply, return and exhaust systems. (7) Electrical drawings shall include the following: (a) a certification that all electrical work and equipment are in compliance with all applicable local codes and laws and that all materials are currently listed by recognized testing laboratories; (b) all electrical wiring, outlets, riser diagrams, switches, special electrical connections, electrical service entrance with service switches, service feeders and characteristics of the light and power current and transformers when located within the building;	A 041		

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A 041	Continued From page 68 (c) a fixture legend; and (d) a graphic coding (with a legend) to show all items on emergency power. (8) Include additional information as needed and requested by the licensing authority. (9) Final working drawings and specifications shall be accurately dimensioned and include all necessary explanatory notes, schedules, legends and have all rooms labeled. The working drawings and specifications shall be complete and adequate for contract purposes. (10) One set of final plans shall be submitted to the licensing authority for review and approval prior to the commencing of construction. All construction shall be executed in accordance with the approved final plans and specifications. (11) Review and approval of building plans by the licensing authority does not eliminate responsibility of the applicant to comply with all applicable laws, rules and ordinances. (12) The final approval of building plans and specifications shall be acknowledged in writing by the licensing authority. (13) The approved building plans shall be kept at the facility and readily available at all times. D. Fire resistance. Required building construction and fire resistance shall be in accordance with the state building code and the fire code. Facilities with nine (9) or more residents shall be protected throughout by an approved automatic fire protection (sprinkler) system. E. Prohibition of mobile homes. For facilities with four (4) or more residents, trailers and mobile homes shall not be used. F. Construction. Construction shall commence within one hundred eighty (180) calendar days of the date of receipt of approval (unless a written extension is requested by the facility and approved by department). This approval shall in	A 041		

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A 041	Continued From page 69 no way permit or authorize any omission or deviation from the requirements of any restrictions, laws, ordinances, codes or standards of any regulatory agency. [7.8.2.41 NMAC - Rp, 7.8.2.41 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.41 B (1) This is a repeat deficient practice from survey's dated 03/30/16 and 11/15/16. Based on observation and interview, the facility failed to provide Handicapped Access/Egress (exiting to the public way) from street level to the second level main entrance and access to the rear yard from the front of the building. There is an exit on the north side rear of the facility, but if a fire or other emergency happened in the rear of the facility, clients and staff would not be able to use this exit. In addition, there is no Handicapped access for the interior stairs leading from the second level to the first level. The lack of Handicap Access/Egress can cause harm to all 6 (R #s 1-6) Residents, identified by the resident census list provided by the Administrator on 02/07/18, by delaying egress (exiting to a public way) for clients in the event of a fire or other emergency. The findings are: A. On 02/14/18 at 1:45 pm, during observation a set of eight concrete stairs, leading from street level to the second level plus four additional steps to reach the main entrance, without handicapped ramps. B. On 02/14/18 at 1:50 pm, during observation of	A 041		

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A 041	Continued From page 70 there were four additional steps along the sidewalk on the north side leading to the back yard area of refuge, without handicap ramps. C. On 02/14/18 at 2:00 pm, during an interview, Direct Care Staff (DCS #2) stated they use the rear entrance on the north side to egress in the event of an emergency, however, she did acknowledged this finding. D. On 02/14/18 at 2:10 pm, during observation of there was no handicap access/egress capability for the interior stairway between the first and second level. E. On 02/14/18 at 2:15 pm, during an interview, DCS #2 stated there was no need for handicap access on the interior stairs but, she did acknowledge this finding.	A 041		
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]	A 042		

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A 042	Continued From page 71 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 and presentable condition. 2. The grounds were free of safety hazards. This deficient practice has the potential for all 6 (R #s 1-6) residents identified on the census provided by the Administrator on 02/07/18, to be at risk of injury due to safety hazards in the back yard, facility's flooring, and maintenance of the building. The findings are: Findings for Flooring A. On 02/14/18 at 11:00 am, during an observation of the flooring in the hallway and in resident room #2, the carpet has a bleached out color stain leading from the hallway to the residents room and in the resident room #3 there was a 6 inch hole of missing carpet fiber making the floor uneven and a tripping hazard. B. On 02/15/18 at 11:45 am, during an interview with the Administrator, she confirmed that the carpet in the the hallway and in residents room #2 has a bleached out color stain and the carpet in R#3 had a 6 inch hole making the floor uneven. Findings for the Grounds C. On 02/14/18 at 2:30 pm, during an observation of the grounds of the facility, there was a torn broken chair and a rusty barbecue grill on south side of the facility outside on the sidewalk blocking the walkway and on the north	A 042		

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A 042	Continued From page 72	A 042		

side of the facility three rolled up carpets, two crates filled with large rocks, and a cinder block on the sidewalk under residents room #1 window pathway blocking the egress thru the window in case of an emergency.

D. On 02/15/18 at 11:45 am, during an interview with the Administrator, she confirmed for the above findings a broken chair, rusty barbecue gill were blocking the pathway and three rolled up carpets, two crates filled with large rocks, and a cinder block were under the residents room #1 window pathway blocking the egress.

Findings for Building

E. On 02/14/18 at 11:10 am, during an observation of the community bathroom on the upper level floor the toilet seat was worn down with scratch marks around the inside and outside rims and scratches on the top.

F. On 02/14/18 at 11:50 am, during an observation of the community bathroom on the lower level of the facility, the cover to the wall extractor fan was missing leaving the fan metal blades exposed.

G. On 02/14/18 at 11:55 am, during observation of the staff restroom, there were wall penetrations around the top part of the shower cubical and a ceiling penetration over the shower cubical.

H. On 02/14/18 at 12:00 pm, during an observation of the wall in the hall way on the lower floor, the electric socket cover was hanging down on the wall on one side exposing the electric wiring.

I. On 02/15/18 at 8:05 am, during an observation

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A 042	Continued From page 73 of the wall and floor on the lower floor water was flowing out of the lower part of the wall onto the floor. J. On 02/15/18 at 8:10 am, during an interview with Direct Care Staff (DCS #3), she confirmed that water was flowing out of the lower part of the wall onto the floor and stated that it always happens after the rain or snow. K. On 02/15/18 at 11:45 am, during an interview with the Administrator, she confirmed that 1. The community bathroom on the upper level floor the toilet seat was worn with scratches around the rims and on top. 2. The community bathroom on the lower level of the facility was missing the extractor fans cover and exposing metal blades. 3. The staff restroom had penetrations in the wall around the shower cubical and a penetration in the ceiling. 4. The wall socket had a cover hanging down on one side exposing electric wires.	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)	A 044		

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A 044	Continued From page 74 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 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	A 044		

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A 044	Continued From page 75 Based on record review, observation, and interview the facility failed to ensure that the fuel fired heater and hot water heater was checked and tested by qualified personnel. This deficient practice could cause harm to all 6 (R #s 1-6) residents identified on the census list provided by the Administrator on 02/07/18, to be at risk of carbon monoxide poisoning. The findings are: A. Record request for the annual fuel-fired heater/water heater inspections conducted by a licensed plumber revealed, no documentation that any inspections had been conducted. B. On 02/14/18 at 10:15 am, during an interview with the Direct Care Staff (DCS #1), she confirmed that the fuel-fired heater and hot water heater have not been inspected annually by a licensed plumber or qualified personnel.	A 044		
A 049	7 NMAC 8.2.49 Doors DOORS: A. No door in any means of egress shall be locked against egress when the building is occupied. (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written	A 049		

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A 049	Continued From page 76 approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities. E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside. F. All doors shall readily open from the inside. G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms. [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.49 A (1) This is a repeat deficiency from previous Life Safety Code (LSC) survey dated 03/30/16. Based on observation and interview, the facility failed to ensure the locking devices on all exit doors were in the unlocked position and does not	A 049		

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A 049	Continued From page 77 require the use of a key, a special device or special knowledge to unlock these locks in the event of an emergency. There is supposed to be only one motion to egress (path to a public way) through these doors. This deficient practice has the potential to prevent evacuation and cause harm by fire/smoke, to all 6 (R #s 1-6) residents, identified on the census list provided by the Administrator on 02/07/18. The findings are: A. On 02/14/18 at 11:45 am, during an observation of the first level main entrance/exit door, there is a locking doorknob, dead bolt, and thumblock on the main door. These devices require three motions to exit. B. On 02/14/18 at 1:40 pm, during an interview, Direct Care Staff (DCS #1) confirmed the findings.	A 049		
A 050	7 NMAC 8.2.50 Exits EXITS: A. The facility shall have at least two (2) approved exits, that do not involve windows and which are remote from each other. B. Facilities with ten (10) or more residents shall have each exit clearly marked with lighted signs having letters at least six (6) inches high and at least three-quarters (3/4) of an inch wide. Exit signs shall be visible at all times. C. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. D. Exits shall be clear of obstructions at all times. E. Exits, exit paths, or means of egress shall not pass through hazardous areas, garages, storerooms, closets, utility rooms, laundry rooms,	A 050		

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A 050	Continued From page 78 bedrooms, or spaces subject to locking. F. For facilities with four (4) or more residents, sliding doors are not acceptable as a required exit. EXCEPTION: Assisted living facilities with three (3) or fewer residents may have sliding doors as required exits. G. When the yard gate(s) is part of the exit access and is locked, the gate shall be connected to the fire protection system and release upon activation of the fire/smoke system or shall have the ability to be unlocked at the gate site. [7.8.2.50 NMAC - Rp, 7.8.2.51 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.50 A E This is a repeat deficiency from Life Safety Code (LSC) survey dated 03/30/16. Based on observation and interview, the facility failed to ensure there are two approved exits for both the first and second levels of the facility. This failed practice would delay egress (path to a public way) in the event of a fire or other emergency, with the potential harm by fire/smoke to all 6 (R #s 1-6) residents identified by the census list, provided by the Administrator on 02/07/18. The findings are: A. On 02/14/18 at 1:30 pm, during an observation of the secondary exit for the second level, residents must pass through the laundry room to exit. B. On 02/14/18 at 1:35 pm, during an observation of the secondary exit on the first level, is located behind a closed door so residents	A 050		

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A 050	Continued From page 79 must pass through a empty resident room to exit. C. On 02/14/18 at 1:40 pm, during an interview, the Assistant Manager confirmed there was not two approved exits for both the first and second levels of the facility.	A 050		
A 054	7 NMAC 8.2.54 Resident Rooms RESIDENT ROOMS: A. The facility ' s bed capacity shall not exceed the capacity approved by the licensing authority. B. Each resident room shall have an outside room with a window. The area of the outdoor window shall be at least one tenth (1/10th) of the floor area of the room. C. Resident rooms shall not be less than seven (7) feet wide in any horizontal dimension. D. There must be no through traffic in resident rooms. Resident rooms must connect directly to other internal common areas of the facility. E. The window shades, drapes, curtains, or blinds in the resident rooms shall be in good repair and of flame-retardant materials. F. Resident rooms may be private or semi-private. Semi-private rooms may not house more than two (2) residents. (1) Private rooms shall have a minimum of one hundred (100) square feet of floor area. The closet and locker area shall not be counted as part of the available floor space. (2) Semi-private rooms shall have a minimum of eighty (80) square feet of floor area for each bed and shall be furnished in such a manner that the room is not crowded and passage out of the room is not obstructed. A separate closet for each resident shall be provided. The closet and locker area shall not be counted as part of the available floor space. The beds shall be spaced	A 054		

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A 054	Continued From page 80 at least three (3) feet apart. G. If a resident chooses not to bring their own furnishings to the facility; each resident room shall be provided with, as a minimum, the following furnishings per resident: (1) a bed that shall be at least thirty-six (36) inches wide, of sturdy construction and in good repair; (2) each bed shall be provided with a clean, comfortable mattress of at least four (4) inches in thickness, which is waterproof, or protected with a waterproof covering and a mattress pad; (3) each bed shall be provided with a clean, comfortable pillow; (4) each bed shall be provided with a pillow case, two (2) clean sheets, blankets and a bedspread appropriate for the weather and the climate; (5) an individual closet or closet area with a clothes rack for hanging clothes and shelves or drawers that are accessible to the resident; (6) a dresser with drawers; (7) a bedside table or desk; (8) a chair; (9) a reading lamp; and (10) a mirror. [7.8.2.54 NMAC - Rp, 7.8.2.55 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.54 E Based on observation and interview, the facility failed to ensure for 2 (R #s 2 and 3) of 6 (R #s 1-6) residents that their shared room had proper window coverings such as shades, drapes, curtains, or blinds. This deficient practices has the potential to cause harm to residents by not allowing significant privacy to each resident. The	A 054		

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A 054	Continued From page 81 finding are: A. On 02/14/18 at 12:10 pm, during an observation of the shared room for R #s 2 & 3 window was only halfway covered with a blanket fastened to one side of the wall leaving the other side of the window without any covering. B. On 02/15/18 at 11:45 am, during an interview with the Administrator, she confirmed that the shared room for R #s 2 and 3, had only a blanket fastened to one side of the wall, leaving the other side of the window was uncovered.	A 054		
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 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	A 061		

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A 061	Continued From page 82 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: NFPA 72 (2010 Edition) 14.2.1.1 Performance Verification. To ensure operational integrity, the system shall have an inspection, testing, and maintenance program. 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. 14.2.1.1.2 Inspection, testing, and maintenance programs shall verify correct operation of the system. 14.2.1.2 Impairments. 14.2.1.2.1 The requirements of Section 10.19 shall be applicable when a system is impaired. 14.2.1.2.2 System defects and malfunctions shall be corrected. 14.2.1.2.3 If a defect or malfunction is not corrected at the conclusion of system inspection, testing, or maintenance, the system owner or the owner's designated representative shall be informed of the impairment in writing within 24 hours. 14.2.2 Responsibilities. 14.2.2.1* The property or building or system owner or the owner's designated representative shall be	A 061		

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A 061	Continued From page 83 responsible for inspection, testing, and maintenance of the system and for alterations or additions to this system. 14.2.2.2 The delegation of responsibility shall be in writing, with a copy of such delegation provided to the authority having jurisdiction upon request. 14.2.2.3 Inspection, testing, or maintenance shall be permitted to be done by the building or system owner or a person or organization other than the building or system owner if conducted under a written contract. 7.8.2.61 A B (1) (4) This is a repeat deficiency from Life Safety Code (LSC) surveys dated 03/30/16 and 11/15/16. Based on observation and interview, the facility failed to provide an approved Fire Alarm and Detection system as required by State Regulations and NFPA 72 National Fire Alarm Code. In the event of a power failure the existing alarm mode will not function in the event of a fire because it does not have a battery back up system and by not having heat/smoke detectors allows a delay in notification of a fire to initiate evacuation. This deficient practice has the potential to harm by fire/smoke all 6 (R #s 1-6) residents identified by the census list provided by the Administrator on 02/07/18. The findings are: A. On 02/14/18, at 10:30 am, during an observation of the alarm mode connected to the house electricity, was observed to not have a battery back-up so the bell alarms at each exit will	A 061		

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A 061	Continued From page 84 still activate if there is a power failure and a fire were to occur. B. On 02/14/18 at 10:31 am, during an observation, there were no heat detectors in the kitchen and furnace room. C. On 02/14/18, at 10:40 am, during an observation of the lower floor, the smoke detector in main room was beeping for 2 days, indicating low battery. D. On 02/15/18 at 9:15 am, during an interview with the Administrator, she confirmed that the bell fire alarm did not have a battery back up system, there are no heat detectors in the kitchen or furnace room, and the smoke detector on the lower floor needed a battery.	A 061		
A 064	7 NMAC 8.2.64 Fire Safety Equivalency System Rating FIRE SAFETY EQUIVALENCY SYSTEM RATING: In facilities without a sprinkler system; the fire safety equivalency system shall be conducted at least annually. The facility shall maintain an evacuation rating score of prompt when a fire safety equivalency system is required. [7.8.2.64 NMAC - Rp, 7.8.2.19 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.64 Based on record review and interview the facility failed to ensure they maintained a Fire Safety Equivalency System (FSES) rating score of	A 064		

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A 064	Continued From page 85 "prompt" required for facilities without a sprinkler system. This deficient practice has the potential for the 6 (R #s 1-6) residents identified on the resident census , provided by the Administrator on on 02/07/18, to be at risk of injury or death in case of fire or other emergency that requires evacuation. The Findings are: A. Record request of the facility's most current FSES forms, revealed that there were no FSES surveys with the residents/facility scores that had been completed by the facility B. On 02/15/18 at 9:00 am, during an interview with the Administrator, she confirmed that the facility had not completed any FSES surveys with the resident/facility scores to ensure there is enough staff on duty at all times to maintain a rating score of prompt at all times.	A 064		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be	A 065		

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A 065	Continued From page 86 requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A This is a repeat deficiency from a Life Safety Code (LSC) survey dated 03/30/16. Based on record review and interview, the facility failed to conduct and document at least one fire drill per month during each 8 hour shift. This deficient practice could cause harm to all 6 (R #s 1-6) residents identified on the census list provided by the Administrator on 02/07/18, by not being prepared to exit the facility in case of a fire. The findings are: A. Record review of the monthly fire drills revealed, only one documented fire drill conducted on 06/24/17 at 3:00 pm, there were no other fire drills recorded. B. On 02/15/18 at 9:00 am, during an interview with the Administrator, she confirmed that the facility has not been conducting/documenting fire drills for the facility since the one recorded on 06/24/17 at 3:00 pm.	A 065		
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training STAFF AND RESIDENT FIRE AND SAFETY TRAINING:	A 066		

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A 066	Continued From page 87 A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month. (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes. (5) The local fire department may be requested to supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC,	A 066		

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A 066	Continued From page 88 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.66 C D (1) (4) This is a repeat deficiency deficiency from Life Safety Code (LSC) survey dated 03/30/16. Based on record review and interview the facility failed to: 1. Provide annual Fire and Disaster training to staff and residents. 2. Conduct and keep a record of the monthly fire drills. This failed practice has the potential for all 6 (R #s 1-6) residents identified on the census list provided by the Administrator on 02/07/18, to be at risk harm, injury, or death from a fire, smoke and delayed evacuation if residents and staff are not prepared. The findings are: A. Record request for the of the staff annual Fire and Disaster training records, revealed there were no records available for review. B. Record request for resident Fire and Safety training records, revealed there was no records available for review C. Record request for the monthly fire drill records, revealed there was only one documented fire drill conducted on 06/24/17. D. On 02/15/18 at 9:00 am, during an interview with the Administrator, she confirmed that the facility has not been conducting/documenting	A 066		

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A 066	Continued From page 89 monthly fire drills consistently, nor have they had or documented fire and safety training for staff and residents.	A 066		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.70 D E Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of	A 070		

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A 070	Continued From page 90	A 070		

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 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

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A 070	Continued From page 91 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 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	A 070		

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A 070	Continued From page 92 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 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	A 070		

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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 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

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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 6 (R #s 1-6)residents on the census provided by the Administrator on 02/07/18, being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents or have a felony conviction. The findings are:

A. Record review of Direct Care Staff (DCS #1's) employee file (hire date 01/15/18) revealed, the EAR clearance was not submitted until 01/16/18.

B. Record review of DCS #2's employee file (hire date 11/30/15) revealed, the EAR clearance was not submitted until 02/29/16 and fingerprints dated 03/17/16 were not submitted within 20 days of hire.

C. On 02/15/18 at 11:45 am, during an interview

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A 070	Continued From page 95 with the Administrator, she confirmed that the DCS #s 1 and 2 EAR clearances were not received prior to hire and DCS #2's fingerprints were not submitted within 20 days of hire.	A 070		