STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5533	A. BUILDING _____ B. WING _____	09/24/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A21	7 NMAC 8.2.21 ADMISSION RECORDS 7.8.2.21 ADMISSION RECORDS: A. In addition to the resident record requirements, the facility must maintain for each resident, the following: B. The resident's written acknowledgement that the facility, prior to or at the time of admission, provided the resident with, and answered any resident questions regarding: (1) The facility's program narrative. (2) The facility's rules. (3) The facility's admission agreement, including costs and charges, refund provision, and termination policies. (4) The facility's bed hold policy. (5) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. Such law includes: Uniform Health Care Decisions Act, Section 24-7A-1 et. seq., NMSA 1978, as amended; New Mexico Durable Power of Attorney for Health Care Decisions, Section 45-5-501, et.seq., NMSA 1978, as amended; New Mexico Living Will and Declaration under the Right to Die Act Section 24 -7-1 et seq., NMSA 1978, as amended. [4-7-97, 7.8.2.21 NMAC - Rn, 7 NMAC 8.2.21, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.21B.(1-5) Based on records review and interview, the facility failed to maintain the resident's written acknowledgement that the facility, prior to or on the date of admission, provided the resident with and answered questions regarding the facility's program narrative, rules, admission agreement, bed hold policy, and resident's rights under NM law regarding health care decisions for 1 of 3	A21	Scanned 11-19-07	

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A21	Continued From page 1 sampled residents (33.3%). The findings are: A. Review of R3's resident records revealed an admission date of 3/26/02. R3's records revealed no written acknowledgement that the facility provided R3 with, and answered questions regarding, the facility's program narrative, rules, admission agreement, bed hold policy, and resident's rights under NM law regarding health care decisions. B. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that the facility failed to maintain R3's written acknowledgement that the above information was provided.	A21	These papers for R-3 were found. They had been misfiled. They have been returned to the correct folders. The director will audit each ~~Acent~~ residents' folder and make any corrections necessary. The director will monitor all residents charts to insure that all paper work is in its' proper folders.	11/30/07
A22	7 NMAC 8.2.22 RESIDENT RECORDS 7.8.2.22 RESIDENT RECORDS: A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include: (1) Admission records as set out in Section 7.8.2.21 NMAC: (2) Within five (5) days of admission: (a) An executed admission agreement. (b) A completed resident assessment form. (c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an acute care hospital, the hospital history and physical report, and the hospital discharge summary may serve as an admission physical. (d) Names, addresses, relationship,	A22		

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A22	Continued From page 2 and phone numbers of family members, and where appropriate, guardians, agents, and any surrogate decision makers. (3) Within thirty (30) days of admission: (a) A admission physical examination report by a licensed health care professional if an examination report was not available within five (5) days of admission. (b) Resident's name, age, recent photograph, social security number, marital status, date of birth, sex, address prior to admission, religion (optional), personal physician, dentist, social history and designated representative or other emergency contact person, language spoken and understood, legal documentation relevant to commitment and/or guardianship status, present medications, and diet required. (c) Any amendments to the admission agreement. (d) The current completed resident assessment form. (e) A completed and current individual service plan. (f) Entries by direct care staff, appropriate health care professionals, or 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 individual service plan. (g) Entries providing a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention, and entries reflecting appropriate follow-up. The maintenance of such written record in the resident record may be by copy of an incident/accident report, if the original	A22	A.22A (1) The residents of Bonney Family Home do not need to sign the Admission Agreement Contract because the residents do not pay for themselves. Bonney Family Home has a contract with Navajo Nation. The agreement is between Bonney Family Home and Navajo Nation Social Service Department. If this will cause a problem the facility will sign a second agreement with the residents 2. This will not affect any other resident who comes in because the facility will make signing the Admission Agreement Contract part of the orientation	

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A22	Continued From page 3 incident/accident report is maintained elsewhere by the facility. (h) A medication record: Medications administered by licensed personnel and/or staff assisting with medications to include: listing all currently ordered medications by name, dosage, administration times; documenting by medication name, dosage, date, and time, each medication administered, with the initials of the individual who administered or assisted with the medication; documentation of errors, omissions, and side-effects of medications; and written consent by resident or guardian for staff to assisting with medications. (i) Date, time and progress note of health services provided by any contract agency. (j) 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. (k) Transfer forms completed, signed, and provided to accepting facility when resident is transferring to a hospital or another health care facility. (l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care facility, upon death or transfer. B. RESIDENT RECORDS, MAINTENANCE: (1) Resident records shall be maintained and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy for maintaining, and confidentiality of resident records, including the authorized release of resident records. (3) Resident records must be maintained by the facility against loss, destruction, and	A22	3. The Director will have the Admission Agreement Contract included with other documents at the Resident's orientation 4. Completed on 11-9-07 A 22A(2) Admission Physical Exam report was on file in Resident's folder indicating Resident was seen July 13, 2006. R1 was admitted 6-8-06. The reason for the delay was that the Resident's doctor was out of town. Hospital did not feel a physical exam was an emergency so we had to wait until the doctor returned 2. This will not affect any resident that comes in to the facility. 3. The Director will see that the updated physical exams are done Annually 4. Completed on 11-9-07	

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A22	Continued From page 4 unauthorized use for a period of not less than three (3) years from the date of discharge. (4) There must be a policy and procedure in place for record retention in the event of facility closure. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 7.8.2.22 NMAC - Rn 7 NMAC 8.2.22, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.22A.(2)(a) Based on records review and interview, the facility failed to maintain records of an executed admission agreement for 1 of 3 sampled residents (33.3%). The findings are: A. Review of R3's resident records revealed an admission date of 3/26/02 but no executed admission agreement with the facility. B. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that the facility failed to maintain records of R3's executed admission agreement. 7.8.2.22A.(2)(c) Based on records review and interview, the facility failed to maintain an admission physical examination report or hospital discharge summary for 3 of 3 sampled residents (100%). The findings are: A. Review of R1's resident records revealed an admission date of 6/8/06 but no admission physical examination report or hospital discharge summary.	A22		

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A22	Continued From page 5 B. Review of R2's resident records revealed an admission date of 8/24/05 but no admission physical examination report or hospital discharge summary. C. Review of R3's resident records revealed an admission date of 3/26/02 but no admission physical examination report or hospital discharge summary. D. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that that the facility failed to maintain admission physical examination reports or hospital discharge summaries for R1-R3.	A22	A22B - R2 Admission Physical Exam was in R2 folder. A copy is attached 2. This will not have an effect on any of the other Residents 3. Director has set up new files for each Resident with dividers and tabs labled for each set of documents. Will continue to monitor to make sure are in Residents' folders. Will do this every 3 months 4. Completed on 11-9-07	
A23	7 NMAC 8.2.23 FAC. REPORTS,RECS.,P & PS & RULES 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND PROCEDURES/ AND RULES: A. REPORTS AND RECORDS: Each facility must keep the following reports, records, and policy and procedures on file at the facility and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or appeals thereto, and complaints. (3) Copy of the latest survey from Environmental Health Authority (if applicable) regarding kitchen and food management and, if private sewage disposal, and private waste disposal. EXCEPTIONS: Adult residential care facilities with three (3) or fewer residents are not	A23		

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A23	Continued From page 6	A23		

required to be inspected by Environmental Health Authority. Facilities exempted by the Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file.

(4) TB test results of staff or any of their family members living in the facility.

(5) One (1) month of menus planned and as served.

(6) Record of fire drills: A record of all fire drills conducted at the facility. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to hold or record fire drills.

(7) Written emergency plans and policies and procedures for medical emergencies, power failure, fire or natural disaster. Such plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes and refuge areas, responsibilities of personnel.

(8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC).

(9) Custodial Drug Permit: A valid Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit.

(10) Vaccination of pets in the facility.

(11) Staff training.

(a) At orientation and on-going.

(b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...)

(c) Fire safety.

(d) First aid.

(e) Safe food handling practices.

(f) Confidentiality of records and

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A23	Continued From page 7 resident information. (g) Infection control (including universal precautions and linen handling). (h) Resident rights. (i) Providing Quality Resident care based on current resident need. (j) Reporting requirements for Abuse, Neglect or Exploitation. (12) A copy of License. (13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions. (14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority. (15) A copy of the floor plans as approved for licensure. B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to but not limited to the following: (1) The use of tobacco and alcohol. (2) The use of the telephone. (3) Operation of television, radio, and stereo. (5) Use and safekeeping of personal property. (6) Meals. (7) Use of common areas. (8) Electric blankets or appliances used by residents. C. 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, (e.g., gas leaks, injuries, transportation, medications,...). (2) Method of keeping informed when residents go outside of the facility (e.g., sign-out	A23	423A The state rules and regulations were misplaced. The booklet has been found and is available for review for anyone who may ask to see it. 2. This will not have an affect on the residents 3. The Director will make sure the booklet is accessable to employees so they will be able to find it if anyone asks 4. Completed on 11-9-07	

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A23	Continued From page 8 sheets). (3) The handling or resident's funds, if the facility provides such services. (4) Reporting of incidents, including abuse, neglect, and exploitation. (5) Handling of complaints. (6) Staff and resident fire and safety training. (7) Smoking. (8) The facility's bed hold policy. (9) Admission agreement. (10) Admission records. (11) Resident records. (12) Program Narrative. (13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (14) Personnel policies. (15) Identifying and safeguarding resident possessions. (16) Securing medical assistance if a resident's own physician is not available. (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles. (19) Staff training for employees who operate motor vehicles to transport residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.23 NMAC - Rn & A 7 NMAC 8.2.23, 8-31-00] This REQUIREMENT is not met as evidenced by:	A23		

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A23	Continued From page 9 7.8.2.23A.(8) Based on records review and interview, the facility failed to maintain a copy of the state licensing rules on file at the facility and make them available for review upon request of the licensing authority: The findings are: A. Review of facility records revealed no evidence that the facility maintained a copy of the Requirements for Adult Residential Care Facilities (7.8.2 NMAC). B. During an interview with S11 on 9/24/07 at 10:00 a.m., S11 acknowledged that the facility failed to maintain a copy of the state licensing rules on file at the facility.	A23		
A26	7 NMAC 8.2.26 RESIDENT ASSESSMENT 7.8.2.26 RESIDENT ASSESSMENT: A. A resident assessment to determine level of function and if the client's needs can be met by the facility. The initial assessment must be completed within five (5) days of admission and reviewed every six (6) months as part of the individual service plan. B. The resident assessment must establish a baseline in the resident's functional status and thereafter, identify resident changes through periodic reassessments. C. The resident assessment must be documented on a state approved resident assessment form and at a minimum include the following: (1) Cognitive patterns. (2) Communication/hearing patterns. (3) Vision patterns. (4) Physical functioning and structural problems.	A26		

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A26	Continued From page 10 (5) Continence. (6) Psycho social well-being. (7) Mood and behavior patterns. (8) Activity pursuit patterns. (9) Disease diagnoses. (10) Health conditions. (11) Oral/nutritional status. (12) Oral/dental status. (13) Skin conditions. (14) Medication use. (15) Special treatment and procedures. D. The resident admission assessment, the physical exam report, and the observation and evaluation of staff with regards to the needs will be used to develop the individual service plan, if needed. If the resident assessment does not indicate a need for an individual service plan, then an individual service plan is not required. However, an individual service plan must be prepared for residents requiring nursing services. [4-7-97; 7.8.2.26 NMAC - Rn, 7 NMAC 8.2.26, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.26A. Based on records review and interview, the facility failed to review resident assessments every six months as part of the individual service plan for 3 of 3 sampled residents (100%). The findings are: A. Review of R1's resident records revealed assessments conducted on the following dates: 10/28/06 and 5/26/07. B . Review of R2's resident records revealed assessments conducted on the following dates: 8/7/06 and 5/26/07.	A26	A26A-1 Resident 1 was an oversight on Director's part. As soon as she realized she was behind the nurse was called to come in and review the assessment to be taken care of. 2. Will not affect the residents 3 Records will be reviewed to maintain timely assessment. Director will monitor every 3 months 4 Corrected 11-9-07 A26B-1 Resident 2 was an oversight on Director's part. As soon as she realized she was behind, a nurse was called to come	

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A26	Continued From page 11 C. Review of R3's resident records revealed assessments conducted on the following dates: 10/28/06 and 5/26/07. D. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that the facility failed to review R1- R3's assessments every six months. However, R1- R3's assessments are current as of 5/26/07.	A26	in and review the assessment to be taken care of. 2. Will not affect the residents 3. Records will be reviewed to maintain timely assessment. Director will monitor every 3 months 4. Corrected on 11-9-07	
A27	7 NMAC 8.2.27 INDIVIDUAL SERVICE PLAN 7.8.2.27 INDIVIDUAL SERVICE PLAN: A. An individual service plan, if prompted by the resident assessment, shall be developed and implemented within fourteen (14) days of admission, and must address those areas of need as identified in the resident assessment. The individual service plan must be reviewed by a licensed nurse at least every six (6) months, and revised as needed at the time of each assessment and consistently implemented in response to the resident's needs. B. The individual service plan must include the following: (1) Description of identified needs as noted in the resident assessment. (2) Written description of what services will 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) Goal and outcome of the service. (8) Documentation of the facility's determination that it is able to meet the needs of the resident.. [7-11-86, 1-11-90, 4-7-97; 7.8.2.27 NMAC - Rn, 7 NMAC.8.2.27, 8-31-00]	A27	A27A Resident 1 was on overnight on Director's part. As soon as she realized she was behind a nurse was called to come in and review the service plan to be taken care of. 2. Will not affect the residents	

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A27	Continued From page 12 This REQUIREMENT is not met as evidenced by: 7.8.2.27A.-B. Based on records review and interview, the facility failed to ensure that resident individual service plans (ISP's) were reviewed by a licensed nurse at least every six months and revised as needed for 3 of 3 sampled residents (100%). The findings are: A. Review of R1's resident records revealed ISP's signed as reviewed by a licensed nurse on the following dates: 6/19/06 and 5/27/07. B. Review of R2's resident records revealed ISP's signed as reviewed by a licensed nurse on the following dates: 8/7/06 and 5/27/07. C. Review of R3's resident records revealed ISP ' s signed as reviewed by a licensed nurse on the following dates: 2/7/06 and 5/27/07. D. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that the facility failed to ensure that R1-R3's ISP's were reviewed by a licensed nurse at least every six months. However, R1-R3's ISP's are current as of 5/27/07.	A27	3 Records will be reviewed to maintain service plan updates. Director will monitor every 3 months 4. Completed 11-9-07 (See inserted page on continuation of A27)	
A36	7 NMAC 8.2.36 MEDICATIONS 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws. A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is	A36		

A27 continued

A27B

Resident 2 was an oversight by the Director As soon as she realized she was behind the nurse was called to come in and review the service plan to be taken care of

2. Will not affect residents
3. Records will be reviewed to maintain timely service plan updates. Director will monitor every 3 months
4. Completed on 11-9-07

A27C

Resident 3 was an oversight by the Director. As soon as she realized she was behind a nurse was called to come in to review the service plan to be taken care of.

2. Will not affect the residents
3. Records will be reviewed to maintain timely service plan up dates. Director will monitor every 3 months.
4. Completed on 11-9-07

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A36	Continued From page 13	A36		

given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications.

C. 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 by the physician and entry into the resident's record.

D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects.

E. Medications prescribed for one resident shall not be used for another resident.

F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include:

(1) Name of resident.
(2) Date started.
(3) Drug product name.
(4) Dosage and form.
(5) Strength of drug.
(6) Route of administration (e.g. "by mouth").
(7) How often medication is to be taken.
(8) Time taken and staff initials.
(9) Dates when the medication is discontinued or changed.
(10) The name and initials of all staff

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A36	Continued From page 14 administering medications. G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting. H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions: (1) The resident is capable of determining when the medication is needed. (2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include: (a) Symptoms that might indicate the use of the medication. (b) Exact dosage to be used. (c) The exact amount of medication to be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist. (e) Possible interactions or side-effects that might occur. (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.36C. Based on observation, records review, and	A36		

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A36	Continued From page 15 interview, the facility failed to obtain a physician's order prior to starting or discontinuing medication for 2 of 3 sampled residents (66.6%). The findings are: A. Observation of R2's stored medications on 9/24/07 at 12:30 p.m. revealed a tube of A&D ointment and a bottle of ciprafloracin. Review of R2's physician's orders revealed no orders for either of these medications. Review of R2's MAR revealed staff initials attesting that these medications had been started. B. Review of R3's physician's orders revealed orders dated 3/13/07 prescribing the following medications: moisturizing cream (PRN), 5 refills; terbinafine cream (use 2x/day), 11 refills; fluocinonide cream (use 2x/day), 3 refills; cyanocobalamin/1000 mcg., quantity 200 tabs., (take 2 tabs/day), 3 refills. None of these medications were present in R3's medication box nor were they listed on R3's MAR. Further, there were no physician's orders discontinuing these medications. C. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that the facility started R2's above medications without documented physician's orders and discontinued R3's above medications without documented physician's orders. 7.8.2.36F. Based on records review and interview, the facility failed to accurately document medications administered to residents on the Medication Administration Record (MAR) for 2 of 3 sampled residents (66.6%). The findings are:	A36	The director will do an audit of all resident MAR's + Drs. orders to insure they match. New orders will be obtained when needed. The director will be responsible for insuring all orders + MAR's are correct.	12/31/07

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A36	Continued From page 16 A. Observation of R1's 9/07 MAR on 9/24/07 at 1:00 p.m. revealed that "LT" initialed the document attesting that R1 was given salsalate on 9/24/07 at 5:00 p.m. B. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that "LT" inaccurately initialed the 9/24/07 salsalate entry on R1's 9/07 MAR as it was not yet 5:00 p.m.. C. Observation of R2's stored medications on 9/24/07 at 1:00 p.m. revealed a bottle of lorazepam (PRN), 60 tablets, filled on 9/17/07. Review of R2's 9/07 MAR and Controlled Substances Log revealed that zero (0) tablets had been given. A count of the drug by S11 indicated that there were 57 tablets remaining in the bottle. D. Review of R2's 9/07 MAR revealed no staff initials attesting that R2 received carbidopa (50/200 mg) on 9/23/07 at 2:00 p.m.; ropinirol (5mg) on 9/22/07 at 12:00 p.m. and on 9/23/07 at 12:00 p.m. and 5:00 p.m.; fluoxetine (20 mg) on 9/23/07 and 9/24/07 at 5:00 a.m. E. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that R2's lorazepam, 60 tablets, was filled on 9/17/07, there were 57 tablets currently remaining in the bottle, and the facility had no documentation accounting for the 3 missing tablets. S11 further acknowledged that R2's 9/07 MAR contained no staff initials attesting that R2 received her dosages of carbidopa, ropinirol, and fluoxetine on the above dates and times.	A36		
A37	7 NMAC 8.2.37 NUTRITION 7.8.2.37 NUTRITION: Each facility shall	A37		

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A37	Continued From page 17 provide planned and nutritionally balanced meals in accordance with the recommended daily dietary allowance from the basic food groups to meet the nutritional needs of the age group. A. At least three (3) meals shall be served daily at regular times, or in accordance with the program narrative. (1) No more than a sixteen (16) hour span may exist between a substantial evening meal and breakfast. Snacks must be made available between meals and in the evening and must be listed on the daily menu. Vending machines shall not be considered a source of snacks. (2) A sufficient amount of time shall be allowed for meals to enable residents to eat at a leisurely pace and to socialize. B. A copy of the current week's menu, including snacks and therapeutic diets, shall be posted where residents and families can see it. Posted menus shall be followed and any substitution must be of equivalent nutritional value and recorded on the posted menu. Menus as served must be kept for thirty (30) days and be available to the public. Identical menus shall not be used on a one (1) week cycle basis. C. Therapeutic diets and prescribed vitamin and mineral supplements shall be given and served only on the written orders of a physician. The physician's order shall become part of the resident's record and shall be updated as necessary. D. The facility shall make every reasonable attempt to accommodate the resident's food preferences, and requests by the resident or the resident's representative to observe religious or cultural dietary practices. E. Personnel handling food must be in good health , practice hygienic food-handling techniques, have good personal grooming, and	A37	A37A Staff Members did not pay attention to the date for the menu plan. This was taken care of immediately The staff members were told to pay more attention when posting menus to make sure dates are correct. 2. This will not affect any of the Residents 3. The Director will monitor menus weekly and make sure dates match each menu correctly. 4. Completed on 11-9-07 A37B Staff Members did not pay attention to the date for menu plans. This was taken care of immediately. The staff members were told to pay more attention when posting menus to make sure dates matched days	

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A37	Continued From page 18 be free from communicable disease transmissible via food. F. Ensure the food is prepared by methods that will conserve nutritive value, enhance flavor, appearance, and is served at the proper temperature and in a form to meet individual needs. G. All residents must be served in a dining room except for residents with a temporary illness, or documented specific personal preference. H. If a resident consistently refuses to eat after encouragement, the resident shall be evaluated by an appropriate health professional. The resident shall be offered fluids more often during the time he/she is refusing to eat. [7-1-64, 9-15-70, 5-26-72, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97;7.8.2.37 NMAC - Rn, 7 NMAC 8.2.37, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.37B. Based on observation, records review, and interview, the facility failed to post the current week ' s menu, including snacks in a conspicuous public place and failed to maintain menus as served for thirty days and make them available to the public. The findings are: A. Observation of material posted in the kitchen on 9/24/07 at 9:30 a.m. revealed a menu dated 9/24/07-10/1/07 and three additional weekly menus, some with prior dates and others undated. B. Review of the menu dated 9/24/07- 10/1/07 revealed that the dates did not correspond with the actual menu. The actual menu covered a 7	A37	2 This will not affect the Residents 3. Director will monitor menus weekly and make sure dates Match Menus Correctly. 4 Completed on 11-9-07 A37C A 30 day meal menu is made and should have been available. I don't know why staff members could not locate the 30 day menu plan. 2. This will not affect the Residents 3. The Director will monitor the monthly 30 day menu plan and make sure staff members know where to locate it. 4 Completed on 11-9-07	

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A37	Continued From page 19 day period starting on Sunday and ending on Saturday. Review of the prior menus as served revealed that they had haphazard dates or were undated. C. During an interview with S11 on 9/24/07 at 9:30 a.m., S11 acknowledged that the facility failed to post the current week ' s menu including snacks and failed to maintain menus as served for thirty days and make them available to the public.	A37		
A38	7 NMAC 8.2.38 FOOD MANAGEMENT 7.8.2.38 FOOD MANAGEMENT: Each facility must store, prepare, distribute and serve food under sanitary conditions and in accordance with the New Mexico Environment Department Food Service and Processor Regulations, if applicable. A. Each facility shall ensure a minimum of a three (3) day supply of perishable and a five (5) day supply of non-perishable or canned food is provided for the residents. B. All milk, to include dry milk products, shall be Grade A pasteurized. C. Potentially hazardous food such as meat, milk, and custard shall be kept at 45 degrees F or below or at 140 degrees F or above. D. Each refrigerator and freezer shall be provided with an indicating thermometer accurate to plus or minus 3 degrees F, located in the warmest section of the refrigeration facility and must be of such type and so situated that the thermometer can be easily read. Thermostats shall not be relied upon to maintain temperatures at correct levels in the absence of thermometers. The temperature of the refrigerator shall be 35 degrees F- 45 degrees F. Freezer temperatures shall be maintained at 0 degrees F or below. E. Refrigerators, freezers, kitchen area and	A38		

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A38	Continued From page 20 food preparation areas shall be kept clean and sanitary at all times. Food stored in refrigerators/freezers shall be covered, dated, and labeled. Unused leftover food shall be discarded after three days. F. Medication, biological, poisons, detergents, and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications may be stored in the refrigerator with food, if they are labeled and locked in a container marked specifically for medication. G. Dishes, utensils, and preparation equipment shall be properly washed and stored to maintain sanitary conditions. H. All garbage and rubbish shall be stored in containers which are waterproof, easily cleaned and have tight fitting lids. Food waste containers shall be kept in good repair, and shall be kept covered except during use. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 4-7-97; 7.8.2.38 NMAC - Rn, 7 NMAC 8.2.38, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.38E. Based on observation and interview the facility failed to cover, date, and label food items stored in refrigerators and discard unused leftover food after three days. The findings are: A. Observation of the refrigerator on 9/24/07 at 11:00 am. revealed an uncovered bowl of jello, salad dressing with a manufacturer's expiration date of 12/26/05, a carton of milk with a manufacturer's expiration date of 9/3/07, several bottles of ketchup labeled and dated 6/13/07, a carton of sour cream labeled and dated 8/6/07, a	A38	A38A The salad dressing, bottles of ketsup and sour cream belong to staff member. She was told not to bring personal items and leave them in the refrigerator. The unwrapped bowl of jello also belonged to a staff member. A verbal warning was given to the employee. The fruits and vegetables will be checked for freshness and will be used before they spoil. 2. Serving fresh food to residents is important in keeping them healthy and feeling content. 3. Director strives to keep food fresh and checks out dated labels on a monthly basis 4. Completed 11-9-07	

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A38	Continued From page 21 bag of celery and onions labeled and dated 8/8/07, and sliced salami labeled and dated 9/5/07. B. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that the facility failed to cover, date, and label food items stored in the refrigerator and/or discard leftover food after three days.	A38	Statement about the onions and celery. If stored properly Onions will keep fresh up to 30 days. If we find "mushy" or soft onions they are disposed of	
A41	7 NMAC 8.2.41 BUILDING CONSTRUCTION 7.8.2.41 BUILDING CONSTRUCTION: When construction of buildings, additions,or alterations to existing buildings are contemplated, plans, code analysis and specifications covering all portions of the work shall be submitted to the Licensing Authority for plan review and approval prior to beginning actual construction. When an addition or alteration is contemplated, plans for the entire facility must also be submitted. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to submit floor plans. A. Building construction and the fire resistance required shall be based upon the capacity of the facility and the residents ability to evacuate the building, in accordance with the Uniform Building Code and NFPA 101 (Life Safety Code). (1) Larger buildings, which are more difficult to evacuate, require more built-in fire protection than smaller buildings. Occupants who are more difficult to evacuate require more built in fire protection than occupants who are easy to evacuate. (2) Evacuation capability, in accordance with NFPA 101, Fire Safety Equivalency System (FSES), must be determined before proceeding to identify applicable building requirements.	A41		

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A41	Continued From page 22 Evacuation capability is not determined on the basis of that resident who is least capable to evacuate, but rather for the entire facility. (3) Facilities not capable of prompt evacuation may not house residents unless the building is constructed to provide protection to these residents. All facilities that are rated as impractical to evacuate shall be protected throughout by an automatic fire protection (sprinkler) system. Facilities that are rated impractical to evacuate and that do not comply with the more restrictive building standards may not continue to care for residents. (4) NEWLY LICENSED AND/OR CONSTRUCTED ADULT RESIDENTIAL CARE FACILITIES: Shall be protected throughout by an approved, automatic fire protection (sprinkler) system. EXCEPTION 1: Sprinklers shall not be required in facilities serving eight (8) or fewer residents maintaining prompt evacuation capability. (5) CURRENTLY LICENSED FACILITIES: Any facility currently licensed on the date these regulations are promulgated and which provides the services prescribed under these regulations, but fails to meet all building requirements, may be granted a variance to continue to be licensed provided: (a) The facility was in compliance with codes and standards at the time of initial licensure. (b) Variances granted will not create a hazard to the health, safety, or welfare of residents and staff. (c) The facility maintains prompt evacuation capabilities. B. Minimum construction requirements shall be a twenty (20) minute fire resistance rating for all bearing walls and partitions, floor construction, roofs, columns, beams, girders and trusses.	A41	A41A 7.8.2.41A All the residents at time of admission are oriented to the facility. They are told as well as shown the exits and quickest way out. Monthly report of fire drills are done. 2. Safety for Residents is important. Will remind residents of the evacuation plan prior to fire drills 3. Director conducts monthly fire drills. Will continue to instruct residents on safety tips and quickest exit out of the building 4 Completed on 11-9-07	

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A41	Continued From page 23 C. NUMBER OF STORIES: Facilities may be of any number of stories if they comply with Uniform Building Code and NFPA 101 (Life Safety Code), with respect to construction and ability of the residents to evacuate in a timely manner. (1) One story buildings may be of Type V-(000) construction if all residents are capable of prompt evacuation. (2) Two story buildings must be of at least one hour construction. Residents who are not capable of prompt evacuation may not be housed above the street-level unless the facility is protected by an approved automatic fire protection (sprinkler) system. (3) Three stories or more require the building to be protected by an approved automatic fire protection (sprinkler) system. D. ACCESS TO PERSONS WITH DISABILITIES: Consultation may be given to new facilities on access requirements upon submission of floor plans during the initial licensing process. With the exception of Adult Residential Care Facilities with three or fewer residents, accessibility to persons with disabilities must be provided in all facilities in accordance with New Mexico Building Code and the American Disabilities Act and shall, as a minimum, include the following: (1) Main entry into the facility must provide wheelchair access. (2) Building must allow access to main living area and dining area. (3) At least one bedroom shall be provided a door clearance of thirty-four (34) inches (thirty six (36) inches is recommended) for wheelchair access. (4) One toilet and bathing facility is required a minimum door clearance of thirty-four (34) inches (thirty six (36) inches is	A41	A41B 7.8.2.4.1 A2. states that fire evacuation is for the entire facility and not just one individual. Fire drill exercises are conducted every month by Bonney Family Home	

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BONNEY FAMILY HOME	802 EAST HILL AVENUE GALLUP, NM 87301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A41	Continued From page 24 recommended) for wheelchair access. This toilet and bathing area must provide a sixty (60) inch diameter clear space (turning radius for a wheelchair). (5) If ramps are provided to the building, a minimum slope of twelve (12)inches horizontal run for each one (1) inch of vertical rise is required. Ramps exceeding a six (6) inch rise shall be provided with handrails. (6) Landings at doorways must have a minimum five (5) foot by five (5) foot level area at the doorway to provide clear space for wheelchair maneuvering. E. PROHIBITION ON MOBILE HOMES: Trailers and mobile homes shall not be used for any part of any adult residential care facility caring for more than three (3) residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.41 NMAC - Rn, 7 NMAC 8.2.41, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.41A. Based on record review and interview, the non-sprinkled facility failed to ensure that it maintained a "prompt" evacuation capability rating by conducting individual Fire Safety Evaluation System (FSES) surveys on 5 of 5 total residents (100%), compiling the results, and determining the facility-wide evacuation capability. The findings are: A. During an interview with S11 on 9/24/07 at 10:30 a.m., S11 revealed that the facility, licensed for 6 residents, had a current census of 5 residents (R1-R5). B. Review of facility records revealed no evidence	A41		

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A41	Continued From page 25 of individual FSES fire evacuation surveys for R1-R5 and no evidence of facility-wide evacuation capability based on results of the individual surveys. C. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that the facility failed to ensure that it maintained a "prompt" evacuation capability rating by evaluating each resident (R1- R5), compiling the results, and obtaining a facility-wide evacuation capability rating.	A41		
A45	7 NMAC 8.2.45 HEATING, VENTILATION AND AIR-CONDITIONING 7.8.2.45 HEATING, VENTILATION AND AIR-CONDITIONING: A. Heating, air-conditioning, piping, boilers, and ventilation equipment must be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities must 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 must provide a minimum temperature of seventy (70) degrees Fahrenheit in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device may be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances must be permanently anchored and kept away from flammables such as curtains, bedcoverings, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or danger from electrical shock.	A45		

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A45	Continued From page 26 D. Fireplaces and open flame heating are not permitted to be utilized in sleeping rooms. E. Gas fired water heaters must not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. A facility must 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 must be screened for the control of insects and rodents. Screen doors must be equipped with self-closing devices. H. A facility must be provided with a system for maintaining residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard or danger from electrical shock. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7-1-64, 9-15-70 9-24-76, 7-11-86, 4-7-97;7.8.2.45 NMAC - Rn, 7 NMAC 8.2.45, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.45A. Based on record review and interview, the facility failed to provide documentation that its fuel-fired (gas) heater had been checked, tested, and maintained annually by qualified personnel. The findings are: A. Review of facility records revealed no evidence that the facility's gas heater had been inspected annually by qualified personnel. B. During an interview with S11 on 9/24/07 at 10:00 a.m., S11 acknowledged that the facility	A45	A45A This was an oversight by the Director and will be corrected. 2. For safety of Residents Director will ensure this oversight does not occur again. 3. The Director will contact the appropriate agency to do an annual inspection. Will contact company to inspect gas heater. 4. Completed on 11-13-07	

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A45	Continued From page 27 failed to provide documentation that its gas heater had been maintained annually by qualified personnel.	A45	A46A A staff member change the thermostat setting because it was not hot enough for her and failed to turn temperature back down. This employee was given a verbal warning and instructed not to touch controls without the Director's authorization 2. Facility will maintain water temperature at the appropriate level for safety of the residents 3. Director will check Thermostat daily and weekly for next 90 days. From there every month to ensure water temperature is at proper level. Director will also keep a record of the date and note the setting 4. Completed 9-24-07	
A46	7 NMAC 8.2.46 WATER 7.8.2.46 WATER: A. A facility must be provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use. Hot and cold running water under pressure must be distributed to all food preparation areas, lavatories, washrooms, and laundries. B. If the water supply is not obtained from an approved public system, the private water system must be inspected, tested, and approved by the Environmental Health Authority prior to licensure. It is the facility's responsibility to insure that subsequent periodic testing or inspection of such private water systems be made at intervals as prescribed by the Environmental Authority. C. The hot water temperature accessible to residents must be maintained at a minimum of 95 degrees Fahrenheit and a maximum of 110 degrees Fahrenheit. Hot water in excess of 110 degrees Fahrenheit is permitted in kitchen and laundry areas, provided residents are supervised to prevent injury. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.46 NMAC - Rn, 7 NMAC 8.2.46, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.46C. Based on observation and interview, the facility failed to maintain the hot water temperature accessible to residents between 95 degrees F and 110 degrees F. The findings are:	A46		

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A46	Continued From page 28 A. Observation and testing of the hot water in the resident's upstairs bathroom with an accurate indicating thermometer on 9/24/07 at 10:00 a.m., revealed that the temperature in the sink was 133.8 degrees F and the temperature in the shower was 133.5 degrees F. B. Observation and testing of the hot water in the resident's downstairs bathroom with an accurate indicating thermometer on 9/24/07 at 10:00 a.m., revealed that the temperature in the sink was 130.3 degrees F and the temperature in the shower was 133.7 degrees F. C. During an interview with the Supervisory Caregiver on 9/24/07 at 10:00 a.m., the Supervisory Caregiver acknowledged that the facility failed to maintain hot water temperature in the resident's bathrooms within the required range.	A46	A48 A A new emergency light has been installed. 2. Proper lighting will be monitored for the safety of the residents 3. Director will monitor every 3 months and keep a record when lighting is checked 4. Completed 11-5-07	
A48	7 NMAC 8.2.48 LIGHTING AND LIGHTING FIXTURES 7.8.2.48 LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances must be lighted to make the area clearly visible. B. Exits, exit-access ways, and other areas used at night by residents and staff must be illuminated by night lights or other continuous lighting. C. Lighting fixtures must be selected and located to accommodate the needs and activities of the residents with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures must be shaded to prevent glare to the eyes of residents	A48		

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A48	Continued From page 29 and staff, and protected from accidental breakage or shattering. E. A facility must be provided with emergency lighting to light exit passageways which will activate automatically upon disruption of electrical service. EXCEPTION: Adult residential care facilities with three (3) or fewer residents may have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.48 NMAC -Rn, 7 NMAC 8.2.48, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.48E. Based on observation and interview, the facility failed to provide emergency lighting which automatically activates upon disruption of electrical service to light exit passageways. The findings are: A. Observation and testing of the facility's emergency lighting fixtures on 9/24/07 at 11:00 a.m. revealed that the downstairs emergency lights were inoperable. B. During an interview with the Supervisory Caregiver on 9/24/07 at 11:00 a.m., the Supervisory Caregiver acknowledged that the facility failed to provide emergency lighting which automatically activates upon disruption of electrical service to light downstairs exit passageways.	A48		
A49	7 NMAC 8.2.49 ELEMENTS OF FACILITY ELECTRICAL SYSTEM	A49		

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A49	Continued From page 30 7.8.2.49 ELEMENTS OF FACILITY ELECTRICAL SYSTEM: A. All fuse and breaker boxes must be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility must know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances must be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords are prohibited. EXCEPTION: The use of a multi-socket United Laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) foot in length is permitted. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.49 NMAC - Rn, 7 NMAC 8.2.48, 8-31-00] K This REQUIREMENT is not met as evidenced by: 7.8.2.49A. Based on observation and interview, the facility failed to label fuse and breaker boxes to identify the areas of service. The findings are: A. Observation of the breaker box on 9/24/07 at 11:00 a.m. revealed that several breakers were unlabeled. B. During an interview with the Supervisory Caregiver on 9/24/07 at 11:00 a.m., the Supervisory Caregiver acknowledged that the	A49	A49A An electrician has been contacted to come and label the circuit breaks box correctly. 2. This will not affect the residents. 3. The Director will ensure the breaker box has been labeled and will monitor this every 6 months 4. Complited on 11-13-07	

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A49	Continued From page 31 facility failed to label breakers to identify the areas of service.	A49		
A55	7 NMAC 8.2.55 RESIDENT ROOMS 7.8.2.55 RESIDENT ROOM: A. Each resident room must be an outside room with a window. The area of the outdoor window shall be at least 1/10th the floor area of the room. B. There must be no through traffic in resident rooms. C. Resident rooms must communicate directly with other areas of the facility. Toilet and bathing facilities must be located to meet the needs of the residents. D. Resident rooms may be private or semi-private. Semi-private rooms may not house more than two (2) residents. EXCEPTION: Facilities that provide programmatic services for alcohol or drug dependency on a short term (30-60 days) may have dormitories with no limitation on number of residents as long as minimum square footage requirements are met. (1) Private Rooms: must have a minimum of one hundred (100) square feet of floor area. Closet and locker area shall not be counted as part of the available floor space. (2) Semi-Private Rooms: must have a minimum of eighty (80) square feet of floor area for each bed and be furnished in such a manner that the room is not crowded or passage out of the room is obstructed. Closet and locker area shall not be counted as part of the available floor space. (3) Dormitories/Wards: must have a minimum of sixty (60) square feet of floor area for each bed. Closet and locker area shall not be counted as part of the available floor space. E. If a resident chooses not to bring in	A55		

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A55	Continued From page 32 his/her own furnishings, each resident room shall be provided with, as a minimum, the following per resident: F. Furnishings: (1) Resident beds 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 climate. (5) Beds shall be spaced at least three (3) feet apart. (6) An individual closet or closet area with a clothes rack for hanging clothes and shelves or drawers that are accessible to the resident. (7) A bedside table or desk. (8) A chair. (9) A reading lamp. (10) A mirror in the resident room. (11) Window shades, drapes, curtains, or blinds, in good repair and of flame-retardant materials. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.55 NMAC - Rn, 7 NMAC 8.2.55, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.55F.(6) Based on observation and interview, the facility failed to provide each resident with the following	A55	A55A All residents rooms will be provided with a reading lamp. 2 This will not affect any new residents coming in 3. Director will see that all residents have a reading light in their room 4. 11-9-07 A55B The curtain rod in this room has been repaired and the curtain rehung. 2 Will not affect the residents 3. Director will inspect each residents room for needed repair	

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A55	Continued From page 33 furnishings: reading lamps for 5 of 5 total residents (100%). The findings are: A. Observation of resident rooms on 9/24/07 at 11:00 a.m. revealed no evidence of reading lamps for R1-R5. B. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that the facility failed to provide reading lamps for R1-R5. 7.8.2.55F.(11) Based on observation and interview, the facility failed to provide each resident room with window coverings that were in good repair for 1 of 5 total residents (20%). The findings are: A. Observation of R3's window coverings on 9/24/07 at 11:00 a.m. revealed that the curtain rod was falling down on one side because it was not securely fastened to the wall. B. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that the window coverings in R3's room were not in good repair.	A55	every 30 days for the next 6 months and then check every six months. 4 Completed on 11-9-07	
A60	7 NMAC 8.2.60 FIRE ALARMS, SMOKE DETECTORS, AND OTHER EQUIP 7.8.2.60 FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. FIRE ALARM SYSTEM: A manual fire alarm system shall be provided. The manual fire alarm must be inspected and approved in writing by the fire authority having jurisdiction. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a fire alarm system. B. SMOKE AND HEAT DETECTION:	A60		

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A60	Continued From page 34 Approved smoke detectors shall be installed on each floor to provide when activated an alarm which is audible in all sleeping areas. Areas of assembly such as the dining and living room 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 must be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all enclosed kitchens and also powered by the house electrical service. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.60 NMAC - Rn, 7 NMAC 8.2.60, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.60B. Based on observation and interview, the facility failed to ensure that its smoke detectors provided an audible alarm when activated. The findings are: A. Observation of the facility's smoke alarms on 9/24/07 at 11:00 a.m. revealed that the alarm activation light was out on the kitchen smoke detector and one downstairs smoke detector. B. During an interview with S11 on 9/24/07 at 11:00 a.m., S11 acknowledged that the facility failed to ensure that its kitchen smoke detector and one downstairs smoke detector provided an audible alarm when activated.	A60	A 60 A A new battery was placed in the smoke alarm. The smoke detector is working properly. 2 For Safety of the residents the smoke detectors will be checked every week to ensure they are working properly. 3. Director will keep a record of when the smoke detectors are checked She will check the alarms each week for 30 days and then monitor every 6 months 4. Completed 11-9-07	

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A62	Continued From page 35	A62	A62A	
A62	7 NMAC 8.2.62 FIRE EXTINGUISHERS 7.8.2.62 FIRE EXTINGUISHERS: A. As approved by the State Fire Marshall or Fire Prevention Authority having jurisdiction must be located in the facility. Facilities must as a minimum have two (2) 2A10BC fire extinguishers, one (1) located in the kitchen or food preparation area, and one (1) centrally located in the facility. All fire extinguishers shall be inspected yearly and recharged as needed. All fire extinguishers must be tagged noting the date of inspection. B. Fire extinguishers, alarm systems, automatic detection equipment, and other fire fighting equipment must be properly maintained and inspected as recommended by the manufacturer, State Fire Marshall, or Fire Authority having jurisdiction. [7-1-64, 9-24-76, 7-11-86, 4-7-97; 7.8.2.62 NMAC - Rn, 7 NMAC 8.2.62, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.62A. Based on observation and interview, the facility failed to ensure that it had a minimum of two 2A10BC fire extinguishers, one located in the kitchen or food preparation area. The findings are: A. Observation of the facility's two fire extinguishers on 9/24/07 at 10:30 a.m. revealed that neither extinguisher was located in the kitchen or food preparation area. B. During an interview with S11 on 9/24/07, at 10:30 a.m., S11 acknowledged that the facility failed to ensure that a fire extinguisher was located in the kitchen or food preparation area.	A62	The fire extinguisher located in the dining room just outside the Kitchen will be moved to in the kitchen area so it is accessable to staff members in case of fire 2. Will not affect the residents 3. The Director will ensure the fire extinguisher is in easy reach for employee 4 Completed 11-9-07	

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A66	Continued From page 36	A66	A66A	
A66	7 NMAC 8.2.66 RELATED REGULATIONS AND CODES 7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96). B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96). C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.66; 7.1.12 (Employee Abuse Registry) Based on record review and interview, the facility failed to maintain records of pre-employment Employee Abuse Registry (EAR) inquiries for 1 of 1 sampled (non-licensed/non-certified) staff hired on or after 1/06. The findings are: A. Review of S13's personnel records revealed that S13 was hired on 9/22/06 but there was no evidence that a pre-employment EAR inquiry had been conducted on S13. B. During an interview with S11 on 9/24/07 at 1:45 p.m., S11 acknowledged that the facility failed to maintain records of a pre-employment EAR inquiry on S13. 7.8.2.66; 7.1.9.8 (Caregivers Criminal History Screening Requirements)	A66	The Director thought since the letter was given to Employee 12 within 30 days, that was all that was needed to comply and nothing further needed to be done 2. Did not affect the residents 3. The Director will apply for the CCHS clearance letter 4 Completed 11-13-07	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5533	A. BUILDING _____ B. WING _____	09/24/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A66	Continued From page 37 Based on records review and interview, the facility failed to maintain appropriate records of caregiver criminal history screening (CCHS) clearances for 2 of 3 sampled caregivers (66.6%). The findings are: A. Review of S12's personnel records revealed that S12 was hired on 11/20/03. Further review of the records revealed a CCHS clearance letter addressed to S12 dated 10/24/03 but there was no evidence that the current facility applied for her CCHS. B. Review of S13's personnel records revealed that S13 was hired on 9/22/06. Further review of the records revealed a CCHS clearance letter addressed to S13 dated 6/26/06 but there was no evidence that the current facility applied for her CCHS. C. During an interview with S11 on 9/24/07 at 1:45 p.m., S11acknowledged that the facility failed to maintain appropriate records of CCHS clearances for S12 and S13.	A66		