STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5842	A. BUILDING _____ B. WING _____	09/10/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY HOME, INC	2021 BARBARA 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
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, 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	A22	Scanned 11/9/07	

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A22	Continued From page 1	A22		

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 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

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A22	Continued From page 2 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 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, within five days of admission, for 2 of 3 sampled residents (66.6%).	A22	A22 7.8.2.22A.(2)(a) R-1's Admission Agreement and date of admission has been done and placed in his file. R-2's Admission Agreement has been done and placed in the file. All resident's folders have been audited and if needed, corrections made. Manager is to monitor all resident charts every six (6) months to insure that all paper work is completed within five (5) days of admission. Date Completed: 11-30-2007	

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A22	Continued From page 3 The findings are: A. Review of R1 ' s resident records revealed no admission date and no executed admission agreement with the facility. B. Review of R2's resident records revealed an admission date of 6/30/07 but no executed admission agreement with the facility. C. During an interview with S13 9/10/07 at 1:00 p.m., S13 examined R1 and R2 ' s resident records and acknowledged that the facility failed to maintain records of executed admission agreements. 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, within 5 days of admission, for 2 of 3 sampled residents (66.6%). The findings are: A. Review of R1 ' 's resident records revealed no admission date and no admission physical examination report or hospital discharge summary. B. Review of R2 ' s resident records revealed an admission date of 6/30/07 but no admission physical examination report or hospital discharge summary. C. During an interview with S13 9/10/07 at 2:30 p.m., S13 acknowledged that that the facility failed to maintain admission physical examination reports for R1 and R2.	A22	A22 7.8.2.22A.(2)(c) R-1's Records were review and the admission date has been found and returned to the file. The medical information from Loving Hearts Care Center has been found in his folder. R-2's Admission record revealed no physical examination. It was scheduled by GIMC for 9-20-2007 but the forms were not taken to the doctor. We only received the physicians orders for medication at that time. A new appointment has been scheduled for 11-16-07 to complete this exam. All resident's folders have been audited and if necessary, corrections made. The manager will create an audit sheet for each resident and will continue with each new resident to insure that all paperwork is done in a timely manner. Administrator will audit every six months.	11/30/07

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A23	Continued From page 4	A23		
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 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	A23		

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A23	Continued From page 5 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 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	A23		

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A23	Continued From page 6 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 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	A23		

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A23	Continued From page 7 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: 7.8.2.23A.(11)(i) Based on records review and interview, the facility failed to maintain records of orientation (initial) and ongoing (annual) staff training in providing quality care based on resident ' s need for 3 of 3 sampled staff (100%). The findings are: A. Review of S11 ' s personnel records revealed that S11 completed an employment application on 8/3/07 (unknown hire date) but there was no documentation of orientation training in providing quality care based on resident need. B. Review of S12 ' s personnel records revealed that S12 completed an employment application	A23	A23 7.8.2.23A.(11)(i) A review of S-11's personnel records revealed there was a date of hire(8-3-2007) and orientation (8-6-2007) located in the folder. Signed by applicant, employer, and trainer. Copy Attached A review of S-12's personnel records revealed there was a date of hire (5-29-2007) and orientation (5-29-2007) located in the folder. Signed by applicant, employer, and trainer. Copy Attached A review of S-13's personnel records revealed there was a date of hire (5-16-2003) and orientation (5-17-2003) located in the folder. Signed by applicant, employer, and trainer. Copy Attached Quality Care Training for residents needs was provided and signed off on. An audit was made of our Quality Care for current resident needs training, and revealed Alzheimer's and Dementia was included in their training. The manager will monitor the employee orientation and in service training. In service orientation in done every 6 months. The manager and employee both sign the form. Copies Attached	11/30/07

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A23	Continued From page 8 on 5/21/07 (unknown hire date) but there was no documentation of orientation training in providing quality care based on resident need. C. Review of S13 ' s personnel records revealed that S13 completed an employment application on 5/8/03 (unknown hire date) but there was no documentation of current training in providing quality care based on resident need. D. During an interview with S13 on 9/10/07 at 2:30 p.m., S13 revealed that the majority of residents were diagnosed with Dementia and/or Alzheimer ' s disease. S13 acknowledged that S11, S12, and S13 ' s files contained no documented training in providing quality care based on the needs of these residents.	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 9 (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 2 of 3 sampled residents (66.6%). The findings are: A. Review of R1 ' s resident records revealed assessments conducted on the following dates: 6/8/06, 6/19/06, and 5/26/07. B. Review of R3 ' s resident records revealed assessments conducted on the following dates: 3/22/06, 6/22/06, and 5/26/07.	A26	A26 7.8.2.26A. A review of R-1's records showed an Assessment was brought to date May 27 and the new assessment was done 10-29-2007 within the six (6) month limit. A review of R-3's records showed an Assessment was brought to date May 27 and the new assessment was done 10-29-2007 within the six (6) month limit. All residents folders were audited and any corrections needed were made. An audit sheet had been generated and will be audited every six (6) months to insure the six (6) month assessments are done in a timely manner. The manager will be responsible for audit of all charts every six (6) months Date completed: Nov. 30, 2007	

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A26	Continued From page 10 C. During an interview with S13 on 9/10/07 at 2:30 p.m., S13 acknowledged that the facility failed to review R1 and R3 ' s assessments every six months. S13 revealed that R1 and R3 ' s assessments are current as of 5/26/07.	A26		
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] This REQUIREMENT is not met as evidenced by: 7.8.2.27A.	A27		

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A27	Continued From page 11 Based on records review and interview, the facility failed to ensure that resident individual service plans were reviewed by a licensed nurse at least every six months and revised as needed for 2 of 3 sampled residents (66.6%). The findings are: A. Review of R1 ' s resident records revealed individual service plans signed as reviewed by a licensed nurse on the following dates: 6/19/06 and 5/27/07. B. Review of R3 ' s resident records revealed individual service plans signed as reviewed by a licensed nurse on the following dates: 3/22/06 and 5/27/07. C. During an interview with S13 on 9/10/07 at 2:30 p.m., S13 acknowledged that the facility failed to ensure that R1 and R3 ' s individual service plans were reviewed by a licensed nurse at least every six months. S13 revealed that R1 and R3 ' s individual service plans are current as of 5/27/07.	A27	A27 7.8.2.27A. R-1's Individual Service Plan has been brought up to date. R-3's Individual Service Plan has been brought up to date. All residents folders were audited and any corrections necessary were made. Manager will be responsible for this audit every six (6) months. Date completed: Dec. 31, 2007	
A28	7 NMAC 8.2.28 RESIDENT ACTIVITIES 7.8.2.28 RESIDENT ACTIVITIES: Each adult residential care facility shall provide or make available, and post, recreational and/or social activities. Each facility must encourage residents to participate in recreational and/or social activities to promote physical, mental, and Psycho social well-being. [6-10-75, 7-11-86, 4-7-97; 7.8.2.8 NMAC - Rn, 7 NMAC.8.2.28, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.28	A28		

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A28	Continued From page 12 Based on observation and interview, the facility failed to provide or make available recreational and/or social activities for 15 of 15 total residents (100%). The findings are: A. Review of the posted September 2007 resident activity schedule revealed that on 9/10/07 crafts/sewing was scheduled for 10:00 a.m.-11:30 a.m. B. Observation on 9/10/07 between 10:00 a.m.-11:30 a.m. revealed no evidence that the scheduled activity was provided or made available. C. During an interview with S13 on 9/10/07 at 11:20 a.m., S13 revealed that the facility, licensed for 16 residents, currently had 15 residents and 2 staff members (S11 and S13) on duty. S13 acknowledged that the facility failed to provide or make the scheduled activity available to the residents.	A28	A28 7.8.2.28 A training with all employees has been scheduled to go over activity schedules and times to insure that all activities are done on time. Activity criteria has been added to the orientation and in service page, and will be conducted for each employee and each new employee. The manager will be responsible for recording the dates of in service training.	12/31/07
A30	7 NMAC 8.2.30 TRANSPORTATION 7.8.2.30 TRANSPORTATION: Each facility licensed pursuant to these regulations must either provide safe transportation or assist the resident in using public transportation. A. The motor vehicle transportation assistance program shall be comprised of but not limited to the following elements: (1) Client assessment, emergency procedures, supervised practice in the safe operation of motor vehicles, familiarity with state regulations governing the transportation of persons with disabilities, maintenance and safety, record keeping, training on hazardous driving conditions and a method for determining and documenting successful completion of the	A30		

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	5842	A. BUILDING _____ B. WING _____	09/10/2007

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A30	Continued From page 13 course. (2) The course requirements above are examples and may be modified as needed. B. To assist residents in using transportation, the facility must be able to provide information on bus schedules, location of bus stops, and telephone numbers of taxi cab companies. [7-11-86, 1-11-90, 4-7-97; 7.8.2.30 NMAC - Rn & A 7 NMAC 8.2.30, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.30A. Based on records review and interview, the facility failed to maintain records of transportation training for 3 of 3 sampled staff (100%) that provide transportation. The findings are: A. Observation of facility staff on 9/10/07 at 9:30 a.m. revealed 1 staff member (S11) present in the facility. B. During an interview with S11 on 9/10/07 at 9:30 a.m., S11 revealed that S13 was also on duty and was transporting residents to their doctors appointments. C. Review of S11, S12, and S13 ' s personnel files revealed no documented transportation training. D. During an interview with S13 on 9/10/07 at 1:30 p.m., S13 revealed that S11, S12 and S13 completed the transportation training tests, the test were submitted to the Assisted Living Services Organization (ALSO) three weeks ago, but the agency had yet to issue training certificates. S13 acknowledged that the facility failed to maintain records of transportation	A30	A30 7.8.2.30A S-11, S-12, and S-13 received their training certificate (Copy Attached) dated September 17, 2007. An audit sheet for Transportation training has been added to each employees folder and will be filled out for current employees yearly and for new employees at orientation. The manager will be responsible for training and recording training information. Employees will be required to sign it. Date completed: Dec 31, 2007	

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A30	Continued From page 14 training for S11, S12, and S13.	A30		
A32	7 NMAC 8.2.32 HANDLING OF EMERGENCIES 7.8.2.32 HANDLING OF EMERGENCIES: A. Each resident or resident representative shall designate upon admission, a physician to be called in case of medical necessity. Each resident or representative may also designate a concerned person to be called in case of an emergency. The facility shall establish a policy to secure medical assistance if the resident's own physician is not available. In the event of an illness or an injury to the resident, an appropriately licensed health professional must be notified by the facility. B. The facility must have available, a first aid kit containing gauze, tape, adhesive, antiseptic, and bandages for emergencies. The first aid kit must be kept in a designated, easily accessible place within the facility. C. An easily accessible and functional telephone for summoning help in case of an emergency must be available in each facility. A pay telephone will not fulfill this requirement. D. A list of emergency numbers, including, but not limited to, Fire Department, Police Department, Ambulance Services, Poison Control, Licensing and Certification, Adult Protective Services, and Ombudsman must be posted near each public telephone in the facility. [7-1-64, 9-15-70, 5-26-72, 7-19-75, 9-24-76, 7-11-86, 1-1-90, 4-7-97; 8.2.32 NMAC - Rn, 7 NMAC 8.2.32, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.32B. Based on observation and interview, the facility failed to maintain a first aid kit containing gauze,	A32	A32 7.8.2.32 A review of our first aid kit, of 188 pieces, revealed Anticeptic Spray was included in the kit. A copy of the outside picture on the first aid kit is attached. The manager will inventory the first aid kit every six (6) months to insure all pieces are in place. Date Completed: Nov. 30, 2007	

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A32	Continued From page 15 tape, adhesive, antiseptic, and bandages for emergencies. The findings are: A. Observation of materials stored in the facility on 9/10/07 at 10:00 a.m. revealed no first aid kit. The facility maintained gauze, tape, adhesive, and bandages in the hall storage closet but there was no evidence of antiseptic. B. During an interview with S13 on 9/10/07 at 2:30 p.m., S13 acknowledged that the facility did not maintain a first aid kit and did not have antiseptic on the premises.	A32		
A35	7 NMAC 8.2.35 CUSTODIAL DRUG PERMIT 7.8.2.35 CUSTODIAL DRUG PERMIT: Any facility licensed pursuant to these regulations who supervises the administration, self-administration, or safeguards medications for residents, must have a current custodial drug permit issued by the State Board of Pharmacy. EXCEPTION: Adult residential care facilities with one (1) resident are not required to have a custodial drug permit. A. PROCUREMENT, LABELING, AND STORAGE: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as required by the individual or specified by the individual's health care plan. The facility shall procure, label, and store medications for residents in a manner which shall be in compliance with state and federal laws. (1) All medications, including non-prescription drugs, will be stored in a locked compartment or in a locked room, as approved by the Board of Pharmacy, and the key will be in the care of the director or designee. (2) Internal medication must be kept	A35		

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A35	Continued From page 16 separate from external medications. Drugs to be taken by mouth will be separated from all other dosage forms. (3) A separate locked compartment will be available in the refrigerator for those items labeled "keep in refrigerator." The refrigerator temperature will be kept between thirty-five (35) and forty-five (45) degrees Fahrenheit. A thermometer is required to be kept in the refrigerator. (4) All medications, including non-prescription medications, must be stored in separate compartments for each resident and all medications will be labeled with the residents' names. (5) A resident may be permitted to keep his/her own medication in a secure place in his/her room for self-administration if the physician's report has deemed it appropriate that the resident do so. (6) The facility may not require the resident to purchase prescriptions from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes must comply with National Fire Protection Association (NFPA) 99. B. CONSULTING PHARMACIST: The facility shall maintain records demonstrating the consulting pharmacist provides the following: (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 must be reported to the Director of the facility and these irregularities must be acted upon. (2) A system of records of receipt and disposition of all drugs in sufficient detail to	A35		

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A35	Continued From page 17 enable an accurate reconciliation. (3) Consultation is 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. [7-1-64, 9-15-70, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.35 NMAC - Rn, 7 NMAC 8.2.35, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.35B.(1) Based on records review and interview, the facility failed to act on irregularities reported by the consulting pharmacist. The findings are: A. Review of consulting pharmacist reports dated 8/14/07 revealed a note instructing facility staff to maintain a count of R1's clonazepam (controlled substance). B. Review of R1's Controlled Substances Log revealed that facility staff began maintaining a running count of clonazepam; the log indicated that 20 pills were remaining in the bottle. C. Observation of R1's stored medications revealed one bottle of clonazepam with 3 pills remaining in the bottle. D. During an interview with S13 on 9/10/07 at 2:20 p.m., S13 acknowledged that the count of clonazepam documented on R1's Controlled Substances Log (20 pills) did not match the actual count of the drug in the bottle (3 pills). Therefore, the facility failed to adequately act on irregularities reported by the consulting	A35	A35 7.8.2.35B. (1) A review of R-1's medication revealed an error made by the medication tech in that the wrong date was added. She received only half of the prescription on the 14th and it was recorded wrong. The control sheet has been corrected to the correct number. An audit will be preformed on all controlled substance and any deficiencies corrected. There will be a training of all medical techs on the importance of counting and signing off for controlled substance to insure all are correct. The manager will be responsible for pulling a weekly audit for four (4) weeks then monthly audit there after. Date completed: Nov 30, 2007	

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A35	Continued From page 18 pharmacist.	A35		
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 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:	A36		

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A36	Continued From page 19 (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 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	A36		

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A36	...Expenses...ge 20 ...to the physician. The facility shall develop and follow a ...policy for unused, outdated or recalled ...tions being kept in the facility. ...9-15-70, 7019074, 3-24-76, 1-11-96, ...0, 4-1-97, 7.8.2.36 NMAC - Rp 7 NMAC ...6-30-00] ...REQUIREMENT is not met ...2.36	A36		

Based on observation, record review, and 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 R1's medications on 9/10/07 at 1:30 p.m. revealed a bottle of levothyroxine. Review of R1's resident records revealed a physician's order prescribing levothyroxine several months prior. Review of R1's [illegible] revealed no levothyroxine (MAR) [illegible] no orders for levothyroxine.

B. During an interview with S13 on 9/10/07 at 1:45 p.m., S13 acknowledged that someone at the facility failed to enter levothyroxine on R1's 9/07 MAR. S13 acknowledged that R1 had inadvertently been discontinued without a physician's order.

C. Observation of R2's stored medications on 9/10/07 at 2:00 p.m. revealed bottles of trazadone and venlafaxine. Review of R2's resident records revealed no physician's orders on file for trazadone and venlafaxine. Review of R2's 9/07 MAR revealed staff initials attesting that staff had assisted R2 with self-administration of trazadone and venlafaxine.

A36
7.8.2.36C

A review of R-1's MAR shows Levothyvoxine was included .
Copy Attached.
Drs. Orders for medication was brought up to date 9/20, the prior drs. orders was not in place. This client was an emergency placement and the first appointment we could get for her was 9/20.
The manager will do an audit of all residents MAR and Drs. orders to insure they match. New orders will be obtained where needed. The manager will be responsible for insuring all orders and MAR's are correct.

Date completed: Dec. 31, 2007

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A36	Continued From page 21 D. During an interview with S13 on 9/10/07 at 2:15 p.m., S13 acknowledged that the facility failed to obtain documentation of physician's orders prior to starting R2's trazadone and venlafaxine. 7.8.2.36F. (8) Based on records review and interview, the facility failed to document medications administered to residents by initialing the Medication Administration Record (MAR) for 3 of 3 residents (100%). The findings are: A. During an interview with S13 on 9/10/07 at 1:30 p.m., S13 revealed that she is the only staff member currently certified to assist residents with medication self-administration and initial MAR's. S13 revealed that she assists the residents during her scheduled shifts and returns to the facility to assist at night and on weekends. B. Review of R1, R2, and R3's MAR's revealed no staff initials attesting that R1, R2, and R3 received their 8:00 a.m. medication dosages on 9/10/07.	A36	A36 7.8.2.36F On September 10, the Med Tech was extremely busy and had not had a chance to update the MAR's. Because of the survey she was even later in updating the MAR's. The copies, of already stated residents MAR's, will show that she has updated them. Three new employees have been certified as Med Techs. The training was done September 17, 2007. The weight of all record keeping will not fall to one person, thus insuring that the MAR's are signed off as medication is given. The manager will schedule trainings yearly and will be responsible to make sure that the training is done.	11/30/07
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	A41		

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A41	Continued From page 22 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. 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	A41		

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A41	Continued From page 23 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. 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	A41		

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A41	Continued From page 24 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 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	A41		

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	5842	A. BUILDING _____ B. WING _____	09/10/2007

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A41	Continued From page 25 by: 7.8.2.41A.(4) Based on observation, records review and interview, the facility failed to ensure that the building was protected throughout by an approved, automatic fire protection (sprinkler) system. The findings are: A. Observation of the interior of the facility on 9/10/07 at 9:30 a.m. revealed that the facility was equipped with an automatic fire protection (sprinkler) system. B. Review of facility records revealed that a fire system sprinkler inspection was conducted by Gallup Sprinkler Services on 5/7/07. The inspection report indicated that the alarm system and the water flow (sprinkler) system were not working. C. During an interview with S13 on 9/10/07 at 2:30 p.m., S13 revealed that the inspector from Gallup Sprinkler Systems did not follow up on the 5/7/07 report. S13 acknowledged that the sprinkler system was not working and she indicated that she would contact Gallup Sprinkler Systems for repair and system approval.	A41	A41 7.8.2.41A. (4) Attached copy of 5-7-07 Gallup Sprinkler Service Report shows everything in good working order. A yearly inspection of this system will be scheduled. The manager will be responsible for scheduling this inspection.	11/30/07
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	A45		

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A45	Continued From page 26 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. 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]	A45		

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A45	Continued From page 27 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. During an interview with the maintenance man on 9/10/07 at 10:30 a.m., the maintenance man revealed that the heater inspection reports were stored off site and he would attempt to locate them. B. During an interview with S13 on 9/10/07 at 2:30 p.m., S13 acknowledged that the facility had no documentation on file verifying that its gas heater had been inspected annually by qualified personnel.	A45	A45 7.8.2.45A. A copy of the heater inspection was supposed to have been faxed to the surveyor. A copy is attached. A yearly inspection of the heater is scheduled by the owner of the building. A copy will be obtained and kept on site. The manager will be responsible to see that this inspection is scheduled.	11/30/07
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	A48		

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A48	Continued From page 28 shaded to prevent glare to the eyes of residents 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 9/10/07 at 10:30 a.m. revealed that fixtures labeled #1, #2, and #3 were inoperable. B. During an interview with the maintenance man on 9/10/07 at 11:00 p.m., the maintenance man acknowledged that emergency lighting fixtures #1, #2, and #3 were inoperable.	A48	A48 7.8.2.48E. An inspection of #1, #2, and #3 emergency lights revealed #1 as inoperable, #'s 2 &3 as operating correctly. A monthly inspection will be done. Any deficiencies will be reported to the manager. The manager will be responsible for scheduling maintance.	12/31/07
A49	7 NMAC 8.2.49 ELEMENTS OF FACILITY ELECTRICAL SYSTEM 7.8.2.49 ELEMENTS OF FACILITY ELECTRICAL SYSTEM:	A49		

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A49	Continued From page 29 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 in the living room on 9/10/07 at 1:00 p.m. revealed that breakers #33-#36 and #38-#40 were unlabeled. B. During an interview with S13 on 9/10/07 at 2:30 p.m., S13 acknowledged that breakers #33-#36 and #38-#40 were unlabeled.	A49	A49 7.8.2.49A. Breakers #33, 36, 38, and 40 have been labeled. These labels are a permanent addition to the list. The maintance man eill make sure these are kept up to date.	11/30/07

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A59	Continued From page 30 A59 7 NMAC 8.2.59 FIRE CLEARANCE AND INSPECTIONS 7.8.2.59 FIRE CLEARANCE AND INSPECTIONS: A. Written documentation from the State Fire Marshall's office or Fire Prevention Authority having jurisdiction indicating a facility's compliance with applicable fire prevention codes shall be submitted to the Licensing Authority prior to issuance of a initial license. B. Each facility shall request from the local fire prevention authorities an annual fire inspection. If the policy of the local fire department does not provide for annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7-1-64, 9-24-76, 7-11-86; 1-11-90, 4-7-97; 7.8.2.59 NMAC - Rn, 7 NMAC 8.2.59, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.59B Based on record review and interview, the facility failed to maintain documentation of an annual fire inspection. The findings are: A. Review of facility records revealed no evidence of an annual fire inspection. B. During a meeting/interview with the Gallup Fire Marshall at the facility on 9/10/07 at 1:00 p.m., the fire marshall revealed that the last fire inspection was conducted on 8/18/06. The fire marshall conducted a preliminary test of the fire alarm system and revealed that it was not	A59 A59	A59 7.8.2.59B. The annual Fire Inspection was done on August 13, 2006. The new fire inspection was done on Nov. 13, 2007. Copy Attached. System was found in complete working order. No information can be found about the Fire Marshall doing a preliminary inspection on Sept. 10. An annual fire inspection will be conducted yearly. The manager will be responsible for scheduling this inspection in a timely manner.	11/13/07

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A59	Continued From page 31 working. C. During an interview with S13 on 9/10/07 at 2:30 p.m., S13 acknowledged that the facility failed to maintain documentation of an annual fire inspection.	A59		
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: 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	A60		

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A60	Continued From page 32 by: 7.8.2.60B. Based on interview the facility failed to ensure that its smoke detectors provide an audible alarm when activated. The findings are: A. During a meeting/interview with the Gallup Fire Marshall at the facility on 9/10/07 at 1:00 p.m., the fire marshall conducted a preliminary test of the fire alarm system and revealed that the system, including the audible alarm, was not working. B. During an interview with S13 on 9/10/07 at 2:30 p.m., S13 acknowledged that the smoke detectors would not provide an audible alarm when activated because the fire alarm system was not working.	A60	A60 7.8.2.60B. The annual Fire Inspection was done on August 13, 2006. The new fire inspection was done on Nov. 13, 2007. Copy Attached. System was found in complete working order including the smoke alarms. No information can be found about the Fire Marshall doing a preliminary inspection on Sept. 10. The smoke alarms will be inspected monthly. The manager will be responsible for scheduling this inspection each month.	11/13/07
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:	A66		

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A66	Continued From page 33 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 2 of 2 sampled (non-licensed/non-certified) staff. The findings are: A. Review of S11's personnel records revealed that S11 completed an employment application on 8/3/07 (unknown hire date) but there was no evidence that a pre-employment EAR inquiry had been conducted. B. Review of S12's personnel records revealed that S12 completed an employment application on 5/21/07 (unknown hire date) but there was no evidence that a pre-employment EAR inquiry had been conducted. C. During an interview with S13 on 9/10/07 at 2:30 p.m., S13 acknowledged that the facility failed to conduct pre-employment EAR inquiries on S11 and S12. 7.8.2.66; 7.1.9.8 (Caregivers Criminal History Screening Requirements) 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 completed an employment application on 5/21/07 (unknown hire date). S12's file contained a CCHS clearance letter addressed to S12 dated 5/12/06 but there was no evidence that the current facility applied for her CCHS.	A66	A66 7.8.2.66; 7.1.12 Employee Abuse Registry) S-11 and S-12's EAR inquiries will be done by Dec. 31, 2007. New employee EAR's will be done before employment. The manager will be responsible for obtaining the EAR before any new employees are hired.	

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A66	Continued From page 34 B. Review of S13's personnel records revealed that S13 completed an employment application on 5/8/03 (unknown hire date). S13's file contained a CCHS clearance letter addressed to S13 dated 2/22/01 but there was no evidence that the current facility applied for her CCHS. C. During an interview with S13 on 9/10/07 at 2:30 p.m., S13 revealed that she and S12 obtained their CCHS clearance letters when they worked at other facilities. S13 acknowledged that the facility failed to maintain appropriate records of CCHS clearances for S12, and S13.	A66	A66 7.8.2.66; 7.1.9.8 (Caregivers Criminal History Screening Requirements) The director thought since there was a letter from S-12, and S-13 employees that was all that was necessary to comply and nothing further needed to be done. The director will apply for the CCHS Letter. Completion Date: Dec. 31, 2007	