

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments The following deficiencies were cited during a Revisit/Follow-up survey completed on 01/16/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.	{A 000}		
{A 017}	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with	{A 017}		

Division of Health Improvement
LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Improvement

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{A 017}	<p>Continued From page 1</p> <p>medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.17 C (1-2) (4-10) (12)</p> <p>This is an uncorrected deficiency from survey dated 02/15/18</p> <p>Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS) received the following trainings and could provide supporting documentation of twelve (12) hours of the required orientation and annual trainings in:</p> <ol style="list-style-type: none"> 1. Fire Safety and Evacuation training. 2. First aid. 3. Confidentiality of records and resident information. 4. Infection control. 5. Resident rights. 6. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. 7. Smoking policy for staff, residents and visitors. 8. Methods to provide quality resident care. 9. Emergency procedures. 10. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs. 	{A 017}		

Division of Health Improvement

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{A 017}	Continued From page 2 This deficient practice has the potential for all 6 (R #s 1-6) residents identified on the census provided by the House Manager on 01/15/19, to be at risk of harm or injury if staff have not received training on the proper methods of providing care and services. The findings are: A. Record review of DCS #1 and House Manager employee files revealed, no documentation that they completed the following annual trainings: <ol style="list-style-type: none"> 1. Fire safety and evacuation training. 2. First aid. 3. Confidentiality of records and resident information. 4. Infection control. 5. Resident rights. 6. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC. 7. Smoking policy for staff, residents and visitors. 8. Methods to provide quality resident care. 9. Emergency procedures. 10. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs. B. On 01/15/19 at 4:20 pm, during an interview with the Manager, he confirmed that the House Manager and DCS #1 had not completed the annual trainings listed above and that there was no documentation available for review.	{A 017}		
{A 018}	7 NMAC 8.2.18 Policies POLICIES: The facility shall have and implement written personnel policies for the following: A. staff, private duty attendant and volunteer qualifications;	{A 018}		

Division of Health Improvement

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{A 018}	<p>Continued From page 3</p> <p>B. staff, private duty attendant and volunteer conduct; C. staff, private duty attendant and volunteer training policies; D. staff and private duty attendant and volunteer criminal history screening; E. emergency procedures; F. medication administration; G. the retention and maintenance of current and past personnel records; and H. facilities shall maintain records and files that reflect compliance with NM and federal employment rules. [7.8.2.18 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.18 A-C E-H</p> <p>This is an uncorrected deficiency from survey dated 02/15/18</p> <p>Based on record review and interview, the facility failed to have all the required written personnel policies for staff and volunteers. This deficient practice has the potential for all 6 (R #s 1-6) residents identified on the census provided by the House Manager on 01/15/19, to be at risk of harm or injury if staff are not trained or aware of the correct way to implement facility policy and procedures that affect the safety and welfare of the residents. The findings are:</p> <p>A. Record review of the facility's Policy and Procedure Manual revealed that the following required personnel policies were missing:</p>	{A 018}		

Division of Health Improvement

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{A 018}	Continued From page 4 1. Staff, private duty attendant, and volunteer qualifications. 2. Staff, private duty attendant, and volunteer conduct. 3. Staff, private duty attendant, and volunteer training policies. 4. Staff, private duty attendant, and volunteer criminal history screening. 5. Emergency procedures. 6. Medication administration. 7. The retention and maintenance of current and past personnel records. 8. Facilities shall maintain records and files that reflect compliance with NM and federal employment rules. B. On 01/15/19 at 4:20 pm, during an interview with the Manager, he confirmed that there were no written facility personnel policies for the findings listed above.	{A 018}		
{A 020}	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment;	{A 020}		

Division of Health Improvement

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{A 020}	Continued From page 5 (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a	{A 020}		

Division of Health Improvement

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{A 020}	<p>Continued From page 6</p> <p>new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and</p> <p>(14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents.</p> <p>B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following:</p> <ul style="list-style-type: none"> (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). <p>C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to</p>	{A 020}		

Division of Health Improvement

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{A 020}	<p>Continued From page 7</p> <p>be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements.</p> <p>(1) Convene a team, comprised of:</p> <p>(a) the facility administrator and a facility health care professional if desired;</p> <p>(b) the resident or resident ' s surrogate decision maker; and</p> <p>(c) the hospice or home health clinician.</p> <p>(2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall:</p> <p>(a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met;</p> <p>(b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES);</p> <p>(c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and</p> <p>(d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility.</p> <p>(3) The team recommendation shall be maintained on site in the resident ' s file.</p> <p>(4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident.</p> <p>D. Coordination of care.</p>	{A 020}		

Division of Health Improvement

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{A 020}	<p>Continued From page 8</p> <p>(1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers.</p> <p>(2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider.</p> <p>[7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) (8-10) (12) (a-d) (13) Refer to Senate Bill (SB) 0335 - 2013</p> <p>This is an uncorrected deficiency from survey dated 02/15/18.</p> <p>AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:</p> <p>SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.--</p>	{A 020}		

Division of Health Improvement

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{A 020}	<p>Continued From page 9</p> <p>A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings.</p> <p>B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them.</p> <p>C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health."</p> <p>SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.</p> <p>Based on record review and interview, the facility failed to ensure that 2 (R #s 1-2) of 2 (R #s 1-2) residents, whose admission agreements were reviewed for compliance were accurate and compete and included the following required information:</p>	{A 020}		

Division of Health Improvement

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{A 020}	<p>Continued From page 10</p> <ol style="list-style-type: none"> 1. Refund policy for death, transfer, voluntary or involuntary discharge. 2. Facility staffing ratio. 3. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements. 4. Written authorization for staff to assist with medications. 5. The admissions agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: <ol style="list-style-type: none"> a. There shall be a fifteen (15) day written notice of termination given. b. Resident fails to pay. c. Facility ceases to operate. d. Resident's health improves. 6. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. <p>This deficient practice has the potential for residents to be at risk of:</p> <ol style="list-style-type: none"> 1. Resident's estate or responsible party being unaware of any refund that may be due. 2. Being misinformed regarding the number of Direct Care Staff (DCS) that will be available to assist residents on each shift. 3. Being misinformed about the DCS's ability to assist with medications. 4. Not being informed of their rights and responsibilities and the process of staff training requirements in reporting of injuries or incidents of suspected abuse, neglect or exploitation. 5. Being discharged before an appropriate placement was found. 6. Being charged for new/changed care services without the appropriate 30-day notice <p>The findings are:</p>	{A 020}		

Division of Health Improvement

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{A 020}	<p>Continued From page 11</p> <p>A. Record review of R #1's admission agreement (dated 12/12/10) revealed it was missing the following information:</p> <ol style="list-style-type: none"> 1. Refund policy for death, transfer, voluntary or involuntary discharge. 2. Facility's staffing ratio. 3. Written authorization for staff to assist with medications. 4. The admissions agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: <ol style="list-style-type: none"> a. There shall be a fifteen (15) day written notice of termination given. b. Resident fail to pay. c. Facility ceases to operate. d. Residents health improves. 5. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. <p>B. Record review of R# 2's admission agreements (dated 12/23/10 and 06/27/01) revealed it was missing the following information:</p> <ol style="list-style-type: none"> 1. Refund policy for death, transfer, voluntary or involuntary discharge. 2. Facility's staffing ratio. 3. Written authorization for staff to assist with medications. 4. Notification of rights and responsibilities pursuant to the incident reporting intake, processing, and training requirements. 5. The admissions agreement can be terminated by the facility "if" an appropriate placement has been found for the resident under the following circumstances: <ol style="list-style-type: none"> a. There shall be a fifteen (15) day written notice of termination given. b. Resident fail to pay. 	{A 020}		

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{A 020}	Continued From page 12 c. Facility ceases to operate. d. Residents health improves. 6. Facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost of services. C. On 01/15/19 at 1:35 pm, during an interview with the Manager, he confirmed that R #s 1 & 2's Admissions Agreements were missing the required information listed above.	{A 020}		
{A 022}	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific	{A 022}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 022}	<p>Continued From page 13</p> <p>requirements by the local health authority, a copy of that determination must also be maintained;</p> <p>(7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction;</p> <p>(8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks;</p> <p>(9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSSES) rating, if applicable;</p> <p>(10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies:</p> <p>(a) an emergency that affects just the facility; and</p> <p>(b) a region/area wide emergency;</p> <p>(11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC);</p> <p>(12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and</p> <p>(13) vaccination records for pets in the facility.</p> <p>B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority:</p>	{A 022}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 022}	<p>Continued From page 14</p> <p>(1) a copy of the facility license;</p> <p>(2) employee personnel records, including an application for employment, training records and personnel actions:</p> <p>(a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC;</p> <p>(b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and</p> <p>(3) a copy of all waivers or variances granted by the licensing authority.</p> <p>C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident's rights and shall include the following:</p> <p>(1) resident use of tobacco and alcohol;</p> <p>(2) resident use of facility telephone or personal cell phone;</p> <p>(3) resident use of television, radio, stereo and cd;</p> <p>(4) the use and safekeeping of residents' personal property;</p> <p>(5) meal availability and times;</p> <p>(6) resident use of common areas;</p> <p>(7) accommodation of resident's pets; and</p> <p>(8) resident use of electric blankets and appliances.</p> <p>D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas:</p> <p>(1) actions to be taken in case of accidents or emergencies;</p> <p>(2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission;</p> <p>(3) policy for medication errors;</p> <p>(4) method of staying informed when residents</p>	{A 022}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 022}	<p>Continued From page 15</p> <p>are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.);</p> <p>(5) the handling of resident's funds, if the facility provides such services;</p> <p>(6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC;</p> <p>(7) reporting and investigating internal complaints;</p> <p>(8) reporting and investigating complaints to the incident management bureau;</p> <p>(9) staff and resident fire and safety training;</p> <p>(10) smoking policy for staff, residents and visitors;</p> <p>(11) the facility's bed hold policy;</p> <p>(12) admission agreement;</p> <p>(13) admission records;</p> <p>(14) resident records including maintenance and record retention if the facility closes;</p> <p>(15) program narrative;</p> <p>(16) resident's rights with regard to making health care decisions and the formulation of advance directives;</p> <p>(17) personnel policies;</p> <p>(18) identifying and safeguarding resident possessions;</p> <p>(19) securing medical assistance if a resident's own physician is not available;</p> <p>(20) staff training appropriate to staff responsibilities;</p> <p>(21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents;</p> <p>(22) witnessed destruction of unused, outdated or recalled medication by the facility administrator</p>	{A 022}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 022}	<p>Continued From page 16</p> <p>with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident's personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (10) (a) (b) C (5 & 6) D (1-3) (8) (10) (20) (23)</p> <p>This is an uncorrected deficiency from survey dated 02/15/18</p> <p>Based on record review and interview, the facility failed to have all the required facility specific written policies and procedures for staff and residents to review. If the facility does not ensure all staff are receiving proper training and management direction (on all the required trainings, policies and procedures), then the 6 (R #s 1-6) residents on the census provided by the House Manager on 01/15/19, are at risk for harm due to staff not having the required information to ensure resident health, safety, and welfare. The findings are:</p> <p>A. Record request for the facility's written emergency plans revealed that they were missing:</p> <ol style="list-style-type: none"> 1. Written emergency plans (Policies and procedures): <ol style="list-style-type: none"> a. For medical emergencies. b. Power failure, fire or natural disaster. <ol style="list-style-type: none"> i. Plans shall include evacuation 	{A 022}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 022}	<p>Continued From page 17</p> <p>ii. Persons to be notified. iii. Emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies. iv. Plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency.</p> <p>2. The emergency preparedness plan shall address two types of emergencies; a. An emergency that affects just the facility and; b. A region/area wide emergency evacuation plan.</p> <p>B. Record review of the facility "rules," revealed the following rules were missing: 1. Meal availability and times. 2. Resident use of common areas.</p> <p>C. Record request for written policies and procedures concerning the following areas were missing: 1. Actions to be taken in case of accidents or emergencies (not specific). 2. Policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission. 3. Policy for medication errors. 4. Reporting and investigating complaints to the incident management bureau. 5. Mealtimes, daily snacks, menus, special diets, resident's personal preference for eating alone or in the dining room setting.</p> <p>D. On 01/15/19 at 4:20 pm, during an interview with the Manager, he confirmed the findings listed above for missing written facility emergency</p>	{A 022}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 022}	Continued From page 18 plans, rules, and policy and procedures.	{A 022}		
{A 025}	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status;	{A 025}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 025}	<p>Continued From page 19</p> <p>(14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.25 E</p> <p>This is an uncorrected deficiency from survey dated 02/15/18</p> <p>Based on record review and interview, the facility failed to ensure for 2 (R #s 1 and 2) of 2 (R #s 1 and 2) residents whose Evaluations/Assessments were reviewed for compliance that they were reviewed by a Licensed Practical Nurse (LPN), Registered Nurse (RN), or Physicians Extender (PE) every 6</p>	{A 025}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 025}	Continued From page 20 months or when a change of condition occurs. This deficient practice has the potential for the residents to be at risk of not receiving the appropriate care and services needed if the evaluations were not reviewed as required. The findings are: A. Record review of R #s 1 & 2 evaluations revealed they were not signed as reviewed by an LPN, RN, or PE every 6 months or when a change in condition occurred. B. On 01/15/19 at 2:30 pm, during an interview with the Manager, he confirmed that R #s 1 & 2 evaluations were not signed as reviewed by an LPN, RN, or PE every 6 months or when a change in condition occurred.	{A 025}		
{A 034}	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee.	{A 034}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 034}	<p>Continued From page 21</p> <p>(2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms.</p> <p>(3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications.</p> <p>(4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name.</p> <p>(5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate.</p> <p>(6) The facility shall not require the residents to purchase medications from any particular pharmacy.</p> <p>(7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99.</p> <p>(8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document:</p> <p>(a) the type and strength of the schedule II through IV drugs;</p> <p>(b) the date and time staff assisted with self-administration;</p> <p>(c) the resident's name;</p> <p>(d) the prescriber's name;</p> <p>(e) the dose;</p> <p>(f) the signature of the person assisting with delivery of the medication; and</p> <p>(g) the balance of medication remaining.</p>	{A 034}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 034}	<p>Continued From page 22</p> <p>(9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC.</p> <p>(10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility.</p> <p>B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance.</p> <p>(1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours.</p> <p>(2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation.</p> <p>(3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications.</p> <p>(4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]</p>	{A 034}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 034}	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (3)</p> <p>This is an uncorrected deficiency from survey dated 02/15/18</p> <p>Based on record review, observation, and interview, the facility failed to have a separate locked refrigerator for medications that require refrigeration. This deficient practice has the potential to harm all 6 (R #s 1-6) residents, as identified on the census list provided by the Manager on Administrator on 01/15/19, if residents medications are stored with food and medication becomes contaminated with germs and bacteria. The findings are:</p> <p>A. On 01/16/19 at 3:45 pm during an observation of the kitchen, it was observed R #3's four (4) bottles of the medication [REDACTED] were in a locked box stored in the refrigerator along with food.</p> <p>B. On 01/16/19 at 3:48 pm, during an interview with the Manager, he confirmed that R #3's medication [REDACTED] was stored in a locked container in the refrigerator along with food.</p>	{A 034}		
{A 037}	<p>7 NMAC 8.2.37 Laundry Services</p> <p>LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in</p>	{A 037}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 037}	<p>Continued From page 24</p> <p>areas separate from the resident units and shall be provided with necessary washing and drying equipment.</p> <p>(2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only.</p> <p>(3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease.</p> <p>(4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed.</p> <p>(5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms.</p> <p>(6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed.</p> <p>(7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed.</p> <p>(8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly.</p> <p>(9) There shall be a clean, dry, well ventilated storage area provided for clean linen.</p> <p>(10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet.</p> <p>B. Residents may do their own laundry, if it is their preference and they are capable of doing so,</p>	{A 037}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 037}	<p>Continued From page 25</p> <p>or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (10)</p> <p>This is an uncorrected deficiency from survey dated 02/15/18</p> <p>Based on observation and interview, the facility failed to ensure cleaning supplies/chemicals were kept in a secured room, closet, or cabinet. This deficient practice has the potential for all 6 (R #s 1-6) residents identified on the census provided by the House manager on 01/15/19, to be at risk of harm or injury if they were to ingest or spill cleaning supplies/chemicals on their face or body. The findings are:</p> <p>A. On 01/15/19 at 3:00 pm, during an observation of the unlocked kitchen cabinet in the 2nd floor kitchen the following cleaning supplies/chemicals's were observed stored in an unlocked cabinet and accessible to residents:</p> <ol style="list-style-type: none"> 1. (1) gallon pine floor cleaner. 2. (1) 26 oz (ounce) Bottle of dish soap. 3. (1) 50 oz bottle of dish soap. 3. (1) 32 oz bottle of drain cleaner. 4. (1) 15 oz can oven cleaner. 5. (1) 16 oz bottle furniture oil. 6. (1) 32 oz bottle of unmarked liquid (smelled like bleach). <p>B. On 01/15/19 at 3:12 pm, during an interview with the House Manager, she confirmed that the chemicals listed above were stored in the</p>	{A 037}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 037}	Continued From page 26 unlocked kitchen cabinet and accessible to residents.	{A 037}		
{A 042}	<p>7 NMAC 8.2.42 Maintenance of Building and Grounds</p> <p>MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas:</p> <p>A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard.</p> <p>B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.42 B</p> <p>This is an uncorrected deficiency from survey dated 02/15/18</p> <p>Based on observation and interview, the facility failed to ensure that the 2nd floor (main) kitchen was maintained in a safe and presentable condition and free of tripping hazards. This deficient practice has the potential for all 6 (R #s 1-6) residents identified on the census provided by the House Manager on 01/15/19, to be at risk of injury due to safety hazards in the facility's flooring. The findings are:</p>	{A 042}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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{A 042}	Continued From page 27 A. On 01/16/19 at 9:05 am, during an observation of the 2nd floor (main) kitchen in facility, the floor was observed to be covered with vinyl composite tiles (VCT) and is uneven due to cracks from the center of the room to the base of the counters on the East and South sides that present a potential tripping and falling hazard. B. On 01/16/19 at 1:45 pm, during an interview with the House manager, she confirmed that there are cracks in the flooring in the kitchen creating a potential tripping and falling hazard for the residents and staff.	{A 042}		
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall	A 047		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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A 047	<p>Continued From page 28</p> <p>have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.47 D E</p> <p>Based on observation and interview, the facility failed to ensure that:</p> <ol style="list-style-type: none"> 1. There was emergency lighting was on the exterior of the facility. 2. The the porch light outside the north exit door had a protective cover over the exposed light bulbs. <p>This deficient practice has the potential for all 6 (R #s 1-6) residents identified on the census provided by the House Manager on 01/15/19 and all occupants of the building, to be at risk of harm or injuries if there is a power outage or other emergency that requires evacuation and the exits, exit pathways, and sidewalks do not have sufficient lighting to see when exiting the building, or physical harm due to broken glass if the exposed light bulbs burst. The findings are:</p> <p>A. On 01/16/19 at 9:18 am, during an observation of the north Exit on the 2nd floor, the porch light was observed to have no protective cover over the light bulbs.</p> <p>B. On 01/16/19 at 9:48 am, during an observation of the outside of the facility, it was observed that there were no emergency lights on the exterior of the facility to light the east, north (1st/2nd floors), or south exits, exit pathways or</p>	A 047		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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A 047	Continued From page 29 sidewalks. C. On 01/16/19 at 9:52 am, during an interview with the Manager, he confirmed that the 2nd floor North Exit porch light had no protective cover with exposed light bulb and that there is no emergency lighting that activates automatically when the power is out, on the east, north, and south exterior exits and exit pathways/sidewalks.	A 047		
{A 050}	7 NMAC 8.2.50 Exits EXITS: A. The facility shall have at least two (2) approved exits, that do not involve windows and which are remote from each other. B. Facilities with ten (10) or more residents shall have each exit clearly marked with lighted signs having letters at least six (6) inches high and at least three-quarters (3/4) of an inch wide. Exit signs shall be visible at all times. C. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. D. Exits shall be clear of obstructions at all times. E. Exits, exit paths, or means of egress shall not pass through hazardous areas, garages, storerooms, closets, utility rooms, laundry rooms, bedrooms, or spaces subject to locking. F. For facilities with four (4) or more residents, sliding doors are not acceptable as a required exit. EXCEPTION: Assisted living facilities with three (3) or fewer residents may have sliding doors as required exits. G. When the yard gate(s) is part of the exit access and is locked, the gate shall be connected to the fire protection system and release upon activation of the fire/smoke system or shall have	{A 050}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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{A 050}	<p>Continued From page 30</p> <p>the ability to be unlocked at the gate site. [7.8.2.50 NMAC - Rp, 7.8.2.51 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.50 A E</p> <p>This is an uncorrected deficiency from survey dated 02/23/18.</p> <p>Based on observation and interview, the facility failed to ensure that the path of exit to evacuate during an emergency, does not pass through the laundry room. This failed practice has the potential for all 6 (R #s 1-6) residents identified on the census provided by the Manager on 01/15/19 to be at risk if harm, injury of death in the event of a fire or other emergency if the egress (path to a public way), becomes blocked by by flames/smoke and/or laundry items if, there is no barrier between the egress and the laundry room. The findings are:</p> <p>A. On 01/16/19 at 10:45 am, during an observation of the east emergency exit on the second floor, it was observed that the residents would have to go through the laundry room to exit the facility.</p> <p>B. On 01/16/19 at 11:00 am, during an interview with the Manager, he confirmed that the residents would have to go through the laundry room to exit the facility through the East emergency exit on the second floor.</p>	{A 050}		
{A 061}	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip	{A 061}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 061}	<p>Continued From page 31</p> <p>FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT:</p> <p>A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction.</p> <p>B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors.</p> <p>(1) Detectors shall be powered by the house electrical service and have battery back up.</p> <p>(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.</p> <p>(3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing.</p> <p>(4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service.</p> <p>[7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.61 B (2)</p> <p>This is an uncorrected deficiency from survey dated 02/15/18</p> <p>Based on observation and interview, the facility failed to ensure that the fire alarm system has a battery back system. This deficient practice has the potential for all 6 (R #s 1-6) residents</p>	{A 061}		

Division of Health Improvement

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{A 061}	Continued From page 32 identified on the resident list provided by the House Manager on 01/15/19, and all occupants of the building to be at risk of harm, injury, or death if a fire were to occur. The findings are: A. On 01/15/19 at 4:00 pm during an observation, the Fire Alarm System was observed to not have a battery back up system. B. On 01/15/19 at 4:10 pm during an interview with the Manager, he confirmed that the fire alarm system has no battery back up system. He stated that the entire system needed to be replaced.	{A 061}		
{A 064}	7 NMAC 8.2.64 Fire Safety Equivalency System Rating FIRE SAFETY EQUIVALENCY SYSTEM RATING: In facilities without a sprinkler system; the fire safety equivalency system shall be conducted at least annually. The facility shall maintain an evacuation rating score of prompt when a fire safety equivalency system is required. [7.8.2.64 NMAC - Rp, 7.8.2.19 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.64 This is an uncorrected deficiency from survey dated 02/15/18. Based on record review and interview, the facility failed to ensure the safety and welfare for 6 (R #s 1-6) of 6 (R #s 1-6) residents whose files were reviewed for compliance, had the required	{A 064}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 064}	Continued From page 33 completed Fire Safety Equivalency System (FSES) ratings evaluation forms. This deficient practice has the potential for residents to be at risk of injuries, burns, and smoke inhalation if a fire was to occur and there was not enough staff on duty and available to residents are unable to exit the facility promptly. The findings are: A. Record review of R #s 1-6 resident or facility files revealed no documentation of FSES rating evaluation forms in the files. B. On 01/15/19 at 3:52 pm during an interview with the Manager, he confirmed that there was no documentation of FSES rating evaluation forms in R #s 1-6 resident or facility files and stated that the facility had not been completing the FSES ratings for any residents.	{A 064}		
{A 066}	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall	{A 066}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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{A 066}	<p>Continued From page 34</p> <p>be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies.</p> <p>D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month.</p> <p>(1) Fire drills shall be held at different times of the day, evening and night.</p> <p>(2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced.</p> <p>(3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed.</p> <p>(4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes.</p> <p>(5) The local fire department may be requested to supervise and participate in the fire drills.</p> <p>[7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.66 A B C</p> <p>This is an uncorrected deficiency from survey dated 02/15/18</p> <p>Based on record review and interview the facility failed to ensure that:</p> <p>1. The Direct Care Staff (DCS) have received fire safety and evacuation training at orientation and annually.</p>	{A 066}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 066}	<p>Continued From page 35</p> <p>2. Residents/Family members received fire safety and evacuation training that included a tour of the facility, the location of the exits, fire extinguishers, and telephones, and were instructed in the actions need to be taken in case of fire or other emergencies that require evacuation upon admission.</p> <p>These deficient practices have the potential for all 6 (R #s 1-6) residents listed on the census, provided by the House manager on 01/15/19 and all occupants, to be at risk of harm, injury, or death if a fire or other emergency were occur because:</p> <p>1. The DCS have not received fire safety and evacuation training and do not know how to safely evacuate the residents and other occupants of the facility.</p> <p>2. Residents/family members do not know where the fire safety equipment is, the evacuation route, and/or where the exits are.</p> <p>The findings are:</p> <p>Findings related to DCS training:</p> <p>A. Record request of the training records for DCS #1's revealed no documentation that they received any fire safety and evacuation training at orientation or annually.</p> <p>B. On 01/15/19 at 4:20 pm, during an interview with the Manager, he confirmed that DCS #1 had not received any fire safety and evacuation training at orientation or annually.</p> <p>Findings related to resident/family training</p> <p>C. Record review of R #s 1 and 2 Admission Agreements revealed no documentation that</p>	{A 066}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL STREET GALLUP, NM 87301
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{A 066}	Continued From page 36 residents and/or families received any fire safety and evacuation training upon admission. D. On 01/15/19 at 1:35 pm, during an interview with the Manager, he confirmed that neither residents and/or families received any fire safety and evacuation training upon admission.	{A 066}		