Division of Health Improvement

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 _____	C 12/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY 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
A 000	Initial Comments A Complaint investigation was completed for intake #NM00027798 for NMAC 7.8.2 regulations governing Assisted Living facilities. The Complaint was substantiated for allegation of neglect with deficiencies cited.	A 000	Scanned 3-11-11 JM	
A 013	7 NMAC 8.2.13 Grounds for Revocatio, Suspension or Denial GROUNDS FOR REVOCATION, SUSPENSION OR DENIAL OF INITIAL OR RENEWAL OF LICENSE, OR THE IMPOSITION OF SANCTIONS OR CIVIL MONETARY PENALTIES: A. When the licensing authority determines that an application for the renewal of a license will be denied or that a license will be revoked, the licensing authority shall provide written notification to the facility, the residents and the surrogate decision makers for the residents. B. After notice to the facility and an opportunity for a hearing, the department may deny an initial or renewal application, revoke or suspend the license of a facility or may impose an intermediate sanction and a civil monetary penalty as provided in accordance with the Public Health Act, Section 24-1-5.2 NMSA 1978. C. Grounds for implementing these penalties may be based on the following: (1) failure to comply with any provision of this rule; (2) failure to allow a survey by authorized representatives of the licensing authority; (3) the hiring or retaining of any staff or permitting any private duty attendant or volunteer to work with residents that has a disqualifying conviction under the requirements of the Caregiver ' s Criminal History Screening Program, 7.1.9	A 013		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Julia Bonney TITLE Director (X6) DATE 3/7/11

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A 013	Continued From page 1 NMAC; (4) the misrepresentation or falsification of any information on the application forms or other documents provided to the licensing authority; (5) repeat violations of this rule; (6) failure to maintain or provide services as required by this rule; (7) exceeding licensed capacity; (8) failure to provide an acceptable plan of correction within the time period established by the licensing authority; (9) failure to correct deficiencies within the time period established by the licensing authority; (10) failure to comply with the incident reporting requirements pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; and (11) failure to pay civil monetary penalties pursuant to Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC. [7.8.2.13 NMAC - Rp, 7.8.2.13 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.13 - GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES: B. A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing AND C. Grounds for implementing these penalties	A 013	A. The facility will comply with all statements addressed on 7NMAC 8.2.13 B. The facility will provide a saffe enviroment to all residents C. Staff training will be done on Incident Reporting, Intake Processing, within the next 30 days. D. Civil Monetary Penalities has been submitted on 3/7/11. Administrator will monitor and comply on a monthly basis. Complete corrections by 4/1/11	3/8/11

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A 013	Continued From page 2 may be based on the following: 1. failure to comply with provisions of this rule: and 6. failure to provide services as required by this rule Refers to 7.8.2.7 - Definitions - " Neglect " means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness and is defined in the Incident Reporting Intake, Processing & Training Requirements, 7.1.13 NMAC. Based on record review, observation and interview, the facility failed to ensure that necessary awake staffing was provided to the population of this facility to avoid physical harm for one (#1) of two sampled residents (#1 and #2). The findings are: A. Review of Complaint Intake #NM00027798 revealed Resident #1 was found deceased outside the facility on the ground after 5:30 am on 11/24/10. During that night, the low temperature was recorded to be 21 degrees Fahrenheit per historical internet data found on weather underground.com on 02/24/11. B. On 12/13/10 at 2:30 pm, during an interview, Staff #3 reported that prior to her death, Resident #1 was reported to be able to walk using side rails, received some help with toileting, and reportedly wandered the halls of the facility during the night shift. C. On 12/14/10 at 12:12 pm, during an interview with Resident #1's son he reported that Resident #1 was blind in one eye and was hard of hearing but was able to walk using facility railing, was	A 013	A. The direct care staff has been inserviced on providing quality services that are necessary to avoid any physical harm, mental harm, and incident reporting, alarm setting each night. The safety of all residents will be and always need to be our high priorty. To prevent an incident like this from happening again. Inservice done to all staff members on 12/1/10. attached is the staff meetings B. Bonney Home, Inc., After the incident, have reviewed the policy and procedures around the security and implementation of alarm systems in the facility. C. The door alarm policy has been re-emphasised at the staff meeting on 12/1/10. The alarm systems have been checked on 12/17/10 by Advanced Technical Services. atteached is a copy of the service The Administrator will supervise and implement any changes over the next 12 months.	

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A 013	Continued From page 3	A 013		

mentally clear and had a "good" memory. It was not reported by any of the interviewees why Resident #1 might have gone outside.

D. Review of facility policies and procedures (date not indicated) revealed that the facility staffing procedure was for the facility to be staffed with 24 hour supervision with a 1:16, (staff-to-resident) ratio during the night shift hours. The facility census at the time of the survey was 16 residents.

E. During record review of the October 2010 Monthly Report in Resident #1's chart, it was noted that Resident #1 required total assistance with Activities of Daily Living; was at risk for fall due to poor gait and balance; and required stand-by assistance for ambulation to all destinations. The report also indicated that Resident #1 preferred to sleep most of the day even though the staff tried to keep her awake during the daytime hours. In addition, the report indicated that Resident #1 "was fully awake at 4:00 pm and stays awake until 2:00 - 3:00 am in the morning but not every night." Resident #1's Care Plan dated 06/30/10 noted that the resident exhibited signs of confusion and forgetfulness due to multiple co-morbidities and that re-directing Resident #1 to the destination [resident room, bathroom, dining area] was needed when Resident #1 was in the facility hallway.

F. Field report from the Office of Medical Investigator for case number 2010-05796 dated 11/24/10 reported that Resident #1 had a medical history of Parkinson's disease, Panhypopituitarism, tardive dyskinesia and poor eyesight. Autopsy Report from the Office of the Medical Investigator dated 11/26/2010 notes that

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A 013	Continued From page 4	A 013		

the cause of death was environmental cold exposure (hypothermia) and indicates Shirley Thompson ' s diagnosis of Parkinson ' s disease as a significant contributing condition along with poor eyesight and a night of low temperatures ranging from 16-23 degrees Fahrenheit. Finally, this report notes that according to reports reviewed by the Office of the Medical Investigator, the facility door was left open, the sensor alarm was disabled and notes that the resident had a history of wandering away from the nursing home.

G. On 12/13/10 at 2:30 pm, during an interview, Staff #3 revealed that she was hired to work as a caregiver for the night shift at the facility. Staff #3 reported that she was told (by the Administrator) that she could sleep during the night shift upon hire by facility administration and as a result reported sleeping during her shift. Staff #3 also reported that she continued to work the night shift but stated, "I think it is too much for one person." She reported that sometimes "residents were up at night and [name of Resident #1] would walk hallways at night prior to the incident that resulted in her death.

H. On 12/13/10 at 1:45 pm, during an interview, Staff #2 who was hired to work as a caregiver for residents revealed that she "works the night shift at the facility sometimes and works the shift alone." She reported that she was aware that the facility administration permitted staff to sleep during the night shift but she did not "feel comfortable sleeping during that time."

I. On 12/14/10 at 1:18 pm, an interview with the Administrator who is also the owner of the facility was conducted. The Administrator reported that

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A 013	Continued From page 5 caregivers were permitted to sleep during the night shift but reported that bed checks were to be done every two hours. The Administrator admitted that only one person was alone at the facility for the night shift in spite of the of regulation governing number of staffing for the facility census which noted that "during resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises." NMAC 7.8.2.19(A)(3) - Staffing Ratios.	A 013		
A 019	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises. (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional	A 019		

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A 019	Continued From page 6 staff person immediately available on the premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days. [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refers to 7.8.2.19(A)(3) - Staffing - The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents' needs. Based on record review, observation and interview, the facility failed to ensure that necessary awake staffing was provided to the population of this facility to avoid physical harm for one (#1) of two sampled residents (#1 and #2). The findings are: A. Review of Complaint Intake #NM00027798 revealed Resident #1 was found deceased outside the facility on the ground after 5:30 am on 11/24/10. During that night, the low temperature was recorded to be 21 degrees Fahrenheit per historical internet data found on weather underground.com on 02/24/11.	A 019	A. The facility will provide adequate staffing to provide basic needs, resident assistance and required supervision based on the residents' needs. B. The ratio for the day shift staffing- 8:00am-5:00pm and 9:00am-6:00pm is 2 to 16. The night shift will consist of 2 staff- one shift from 6pm-12:00 midnight, and 12:00 midnight to 8:00am. Both shifts, the staff will be awake at all times during the night working hours. All direct care staff has been trained and on going training will be provided on a quarterly basis. Training will consist of resident assistance, basic care, residents rights, resident care during the night. All residnets will be checked on every 2 hours around the clock. The alarm will be set at 6:00pm when the day shift leaves. The doors will be locked at 9:00 pm. The Administrator, Assistant Manager will monitor on a weekly basis over the next 12 months. Corrections complete by 4/1/11	3/8/11

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A 019	Continued From page 7 B. On 12/13/10 at 2:30 pm, during an interview, Staff #3 reported that prior to her death, Resident #1 was reported to be able to walk using side rails, received some help with toileting, and reportedly wandered the halls of the facility during the night shift. C. On 12/14/10 at 12:12 pm, during an interview with Resident #1's son he reported that Resident #1 was blind in one eye and was hard of hearing but was able to walk using facility railing, was mentally clear and had a "good" memory. It was not reported by any of the interviewees why Resident #1 might have gone outside. D. Review of facility policies and procedures (date not indicated) revealed that the facility staffing procedure was for the facility to be staffed with 24 hour supervision with a 1:16, (staff-to-resident) ratio during the night shift hours. The facility census at the time of the survey was 16 residents. E. During record review of the October 2010 Monthly Report in Resident #1's chart, it was noted that Resident #1 required total assistance with Activities of Daily Living; was at risk for fall due to poor gait and balance; and required stand-by assistance for ambulation to all destinations. The report also indicated that Resident #1 preferred to sleep most of the day even though the staff tried to keep her awake during the daytime hours. In addition, the report indicated that Resident #1 "was fully awake at 4:00 pm and stays awake until 2:00 - 3:00 am in the morning but not every night." Resident #1's Care Plan dated 06/30/10 noted that the resident exhibited signs of confusion and forgetfulness due to multiple co-morbidities and that re-directing Resident #1 to the destination	A 019		

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A 019	Continued From page 8 [resident room, bathroom, dining area] was needed when Resident #1 was in the facility hallway. F. Field report from the Office of Medical Investigator for case number 2010-05796 dated 11/24/10 reported that Resident #1 had a medical history of Parkinson's disease, Panhypopituitarism, tardive dyskinesia and poor eyesight. Autopsy Report from the Office of the Medical Investigator dated 11/26/2010 notes that the cause of death was environmental cold exposure (hypothermia) and indicates Shirley Thompson ' s diagnosis of Parkinson ' s disease as a significant contributing condition along with poor eyesight and a night of low temperatures ranging from 16-23 degrees Fahrenheit. Finally, this report notes that according to reports reviewed by the Office of the Medical Investigator, the facility door was left open, the sensor alarm was disabled and notes that the resident had a history of wandering away from the nursing home. G. On 12/13/10 at 2:30 pm, during an interview, Staff #3 revealed that she was hired to work as a caregiver for the night shift at the facility. Staff #3 reported that she was told (by the Administrator) that she could sleep during the night shift upon hire by facility administration and as a result reported sleeping during her shift. Staff #3 also reported that she continued to work the night shift but stated, "I think it is too much for one person." She reported that sometimes "residents were up at night and [name of Resident #1] would walk hallways at night prior to the incident that resulted in her death. H. On 12/13/10 at 1:45 pm, during an interview,	A 019		

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A 019	Continued From page 9 Staff #2 who was hired to work as a caregiver for residents revealed that she "works the night shift at the facility sometimes and works the shift alone." She reported that she was aware that the facility administration permitted staff to sleep during the night shift but she did not "feel comfortable sleeping during that time." I. On 12/14/10 at 1:18 pm, an interview with the Administrator who is also the owner of the facility was conducted. The Administrator reported that caregivers were permitted to sleep during the night shift but reported that bed checks were to be done every two hours. The Administrator admitted that only one person was alone at the facility for the night shift in spite of the of regulation governing number of staffing for the facility census which noted that "during resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises."	A 019		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse;	A 033		

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A 033	Continued From page 10 (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private	A 033		

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A 033	Continued From page 11 correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal	A 033		

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A 033	Continued From page 12 possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.33(D)(11)(a) - RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. D. To protect resident rights, the facility shall ensure that residents are free from emotional abuse, neglect and misappropriation or exploitation Refers also to 7.8.2.7 - Definitions - " Neglect " means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness and is defined in the Incident Reporting Intake, Processing & Training Requirements, 7.1.13 NMAC. Based on record review and interview, the facility failed to ensure that residents were protected from neglect for one (#1) of two residents (#1	A 033	7.8.2.33D 3/3/11 Residnets Rights A. The residents Rights have been reviewed and presented to all residents in the facility. Each staff member has been given a copy of the residents rights. and inserviced on the rights of each resident. Each resident will be free from any emotional abuse, neglect and misappropriation or exploitation. All Residents will be free to exercise their rights. Administrator and Assistant Manager will monitor and implement inservices to all staff on a yearly basis. correction complete by 4/1/11	

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 _____	C 12/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 033	Continued From page 13 and #2). The findings are: A. Review of Complaint Intake #NM00027798 revealed Resident #1 was found deceased outside the facility on the ground after 5:30 am on 11/24/10. During that night, the low temperature was recorded to be 21 degrees Fahrenheit per historical internet data found on weather underground.com on 02/24/11. B. On 12/13/10 at 2:30 pm, during an interview, Staff #3 reported that prior to her death, Resident #1 was reported to be able to walk using side rails, received some help with toileting, and reportedly wandered the halls of the facility during the night shift. C. On 12/14/10 at 12:12 pm, during an interview with Resident #1's son he reported that Resident #1 was blind in one eye and was hard of hearing but was able to walk using facility railing, was mentally clear and had a "good" memory. It was not reported by any of the interviewees why Resident #1 might have gone outside. D. Review of facility policies and procedures (date not indicated) revealed that the facility staffing procedure was for the facility to be staffed with 24 hour supervision with a 1:16, (staff-to-resident) ratio during the night shift hours. The facility census at the time of the survey was 16 residents. E. During record review of the October 2010 Monthly Report in Resident #1's chart, it was noted that Resident #1 required total assistance with Activities of Daily Living; was at risk for fall due to poor gait and balance; and required stand-by assistance for ambulation to all destinations. The report also indicated that	A 033		

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A 033	Continued From page 14 Resident #1 preferred to sleep most of the day even though the staff tried to keep her awake during the daytime hours. In addition, the report indicated that Resident #1 "was fully awake at 4:00 pm and stays awake until 2:00 - 3:00 am in the morning but not every night." Resident #1's Care Plan dated 06/30/10 noted that the resident exhibited signs of confusion and forgetfulness due to multiple co-morbidities and that re-directing Resident #1 to the destination [resident room, bathroom, dining area] was needed when Resident #1 was in the facility hallway. F. Field report from the Office of Medical Investigator for case number 2010-05796 dated 11/24/10 reported that Resident #1 had a medical history of Parkinson's disease, Panhypopituitarism, tardive dyskinesia and poor eyesight. Autopsy Report from the Office of the Medical Investigator dated 11/26/2010 notes that the cause of death was environmental cold exposure (hypothermia) and indicates Shirley Thompson ' s diagnosis of Parkinson ' s disease as a significant contributing condition along with poor eyesight and a night of low temperatures ranging from 16-23 degrees Fahrenheit. Finally, this report notes that according to reports reviewed by the Office of the Medical Investigator, the facility door was left open, the sensor alarm was disabled and notes that the resident had a history of wandering away from the nursing home. G. On 12/13/10 at 2:30 pm, during an interview, Staff #3 revealed that she was hired to work as a caregiver for the night shift at the facility. Staff #3 reported that she was told (by the Administrator) that she could sleep during the night shift upon hire by facility administration and as a result	A 033		

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A 033	Continued From page 15 reported sleeping during her shift. Staff #3 also reported that she continued to work the night shift but stated, "I think it is too much for one person." She reported that sometimes "residents were up at night and [name of Resident #1] would walk hallways at night prior to the incident that resulted in her death. H. On 12/13/10 at 1:45 pm, during an interview, Staff #2 who was hired to work as a caregiver for residents revealed that she "works the night shift at the facility sometimes and works the shift alone." She reported that she was aware that the facility administration permitted staff to sleep during the night shift but she did not "feel comfortable sleeping during that time." I. On 12/14/10 at 1:18 pm, an interview with the Administrator who is also the owner of the facility was conducted. The Administrator reported that caregivers were permitted to sleep during the night shift but reported that bed checks were to be done every two hours. The Administrator admitted that only one person was alone at the facility for the night shift in spite of the of regulation governing number of staffing for the facility census which noted that "during resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises." NMAC 7.8.2.19(A)(3) - Staffing Ratios.	A 033		