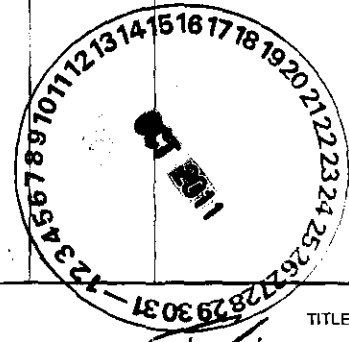
Division of Health Improvement

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 _____	R-C 03/30/2011

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 revisit was conducted on 3/28/2011 with repeat deficiencies cited.	{A 000}	7 NMAC 8.2.13 A. The facility will comply with all statements addressed on 7NMAC 8.2.13 B. The facility will provide a safe environment to all residents. C. Training on incident reporting, intake processing, and alarm setting will be done within the next 30 days. D. Civil monetary penalties have been submitted. E. The administrator and assistant manager will monitor and comply on a yearly basis. F. A meeting was held where the direst care staff have been inserviced on providing quality services that are necessary to avoid any physical, mental, or emotional harm, and alarm setting each night. G. Bonney Home, Inc. has reviewed the policy and procedures around security and the implementation of the alarm systems at the facility. H. The alarm systems are checked daily. Complete correction will be done by 10/17/11	10/12/11
{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	{A 013}		

Scanned 10/20/11 JL



Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jolinda Bonney 10/12/11

Division of Health Improvement

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{A 013}	Continued From page 1 under the requirements of the Caregiver ' s Criminal History Screening Program, 7.1.9 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: This is a repeat deficiency from survey dated 12/14/2010 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	{A 013}		10/12/11

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{A 013}	Continued From page 2 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 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 Based on record review, observation and interview, the facility failed to ensure that a sufficient number of staff was provided to the population of this facility to meet minimum required staffing at night for 16 residents as well as avoid risky ongoing elopements for one (#1) of three (#1, 2 and 3) residents. The findings are: A. On 03/28/11 at 11:00 am, upon entry to the facility and during observation, there were two staff members present, Caregiver #1 and Caregiver #2. Caregiver #1 reported that there were currently 16 residents living in the facility. The licensed capacity of the building was 16 residents. Caregiver #1 was told that the visit was to conduct a re-visit for the December 2010 survey and follow-up on matters pertaining to the staffing situation. B. On 3/28/11 at around 11:05 am, during an interview Caregiver #1 reported that in accordance to the facility policy, the door alarm was to be off during the day shift and turned on at 6:00 pm. During that time, the door alarms were tested to ensure functionality of those alarms. Door alarms were noted to be functional when the	{A 013}		10/12/11

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{A 013}	Continued From page 3	{A 013}		10/12/11

switch was activated by staff inside the office.

C. On 3/28/11 at 11:15 am, during an interview Caregiver #1 reported that earlier in the month, Resident #1 had eloped from the facility on foot and that police had to be called in order to locate him and bring him back to the facility. Review of Police report for case number 2001-00010747 indicates that a Missing Persons Incident was reported on Sunday 03/06/11 at 6:55 pm. The Missing Person was reported to be Resident #1 who was last seen at the facility. Significant to this incident as recounted in the police report, Caregiver #3 reported to police that only one staff member (Caregiver #3) was on shift when Dementia Resident #1 left the facility at around 6:20 pm. Caregiver #3 reported to the police that Resident #1 "has wandered off from the facility before on several occasions." The report also indicated that police officers then proceeded to look for the resident in the immediate area and were unable to locate him.

D. On 03/28/11 at 12:00 pm, during record review of Resident #1's medical file indicated that he was a newer admission to the facility with an admission date of 01/06/11. Resident #1's assessment dated 01/07/11 indicated that he exhibits signs of forgetfulness, poor short term memory and was ambulatory with wandering behavior. Resident #1's physician orders dated 01/04/11 indicated a diagnosis of Rapidly Progressive Dementia. Resident #1's social history indicated that his elopement attempts arise as a result of his dementia and previous occupation as a sheepherder which apparently compelled him to attempt to look for his sheep. Review of the daily log for Resident #1 revealed that he attempted 3 elopements on 01/10/11, 1 attempt on 01/12/11, 1 attempt on 01/25/11, 1

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{A 013}	Continued From page 4 attempt on 02/15/11 in which he jumped the facility fence and started running down the road, 1 attempt on 03/06/11, 1 attempt on 03/07/11 in which he again scaled the facility fence "like a deer" around 6:20 pm and the facility had to call the police to intervene and locate the resident, and 1 attempt on 03/09/11. E. On 03/28/11 at 11:30 am, during an interview with Caregiver #1, she reported that the night shift from 12:00 am until 8:00 am the next morning was still being covered by only one staff member in spite of the fact that there were 16 residents in the building. Similarly, Caregiver #2 reported that during weekends, there was only one staff member present at that facility and available for the needs of the 16 residents. Both staff members reported that no additional staff had been hired so that two people could work the night shift or the weekend shift. Further review of schedules dated 03/06/11 through 04/02/11 revealed the same pattern of only one on site working staff for day shift on the weekends, and one night shift staff scheduled from 12:00 am until 8:00 am, seven days a week, leaving the facility chronically short staffed by 50% in accordance regulations when taking into consideration resident needs and resident census. F. Record review of the staffing schedule for 03/28/2011, it was noted that the Administrator was scheduled on to work day shift. G. On 03/28/11 at 11:40 am, during observation and interview, the Administrator was not present in the building at the time of the observation as scheduled. Staff members #1 and #2 reported that the Administrator was currently "in Phoenix."	{A 013}		10/12/11

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{A 019}	Continued From page 5	{A 019}	7.8.2.19 NMAC (A) (3)	10/12/11
{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 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,	{A 019}	A. Per policy and procedures revisement the facility will provide the staffing ratio per each 24 hours. The ratio for day shift staffing is 2 personnel per 16 residents. The ratio for night shift will be 2 personnel per 16 residents, with each staff member fully awake during their shift. There will be 2 staff members on duty from both 6pm-12 midnight and 12 midnight to 8am. B. All direct care staff has been and will continue to be inserviced on resident assistance, basic care, resident's rights, and resident care. During the night, all residents will be checked every 2 hours. C. The door alarms will be set at 6pm when the day shift staff leaves for day and turned off at 8am by the day staff when they come in. D. The administrator and assistant manager will monitor this on a weekly basis over the next year. Correction complete by 10/17/11	

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{A 019}	Continued From page 6 01/15/2010] This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from the survey dated 12/14/10 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 racord review, observation and interview, the facility failed to ensure that a sufficient number of staff was provided to the population of this facility to meet minimum required staffing at night for 16 residents as well as avoid risky ongoing elopements for one (#1) of three (#1, 2 and 3) residents. The findings are: A. On 03/28/11 at 11:00 am, upon entry to the facility and during observation, there were two staff members present, Caregiver #1 and Caregiver #2. Caregiver #1 reported that there were currently 16 residents living in the facility. The licensed capacity of the building was 16 residents. Caregiver #1 was told that the visit was to conduct a re-visit for the December 2010 survey and follow-up on matters pertaining to the staffing situation. B. On 3/28/11 at around 11:05 am, during an interview Caregiver #1 reported that in accordance to the facility policy, the door alarm was to be off during the day shift and turned on at 6:00 pm. During that time, the door alarms were tested to ensure functionality of those alarms. Door alarms were noted to be functional when the	{A 019}		10/12/11

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{A 019}	Continued From page 8	{A 019}		10/12/11

attempt on 02/15/11 in which he jumped the facility fence and started running down the road, 1 attempt on 03/06/11, 1 attempt on 03/07/11 in which he again scaled the facility fence "like a deer" around 6:20 pm and the facility had to call the police to intervene and locate the resident, and 1 attempt on 03/09/11.

E. On 03/28/11 at 11:30 am, during an interview with Caregiver #1, she reported that the night shift from 12:00 am until 8:00 am the next morning was still being covered by only one staff member in spite of the fact that there were 16 residents in the building. Similarly, Caregiver #2 reported that during weekends, there was only one staff member present at that facility and available for the needs of the 16 residents. Both staff members reported that no additional staff had been hired so that two people could work the night shift or the weekend shift. Further review of schedules dated 03/06/11 through 04/02/11 revealed the same pattern of only one on site working staff for day shift on the weekends, and one night shift staff scheduled from 12:00 am until 8:00 am, seven days a week, leaving the facility chronically short staffed by 50% in accordance regulations when taking into consideration resident needs and resident census.

F. Record review of the staffing schedule for 03/28/2011, it was noted that the Administrator was scheduled on to work day shift.

G. On 03/28/11 at 11:40 am, during observation and interview, the Administrator was not present in the building at the time of the observation as scheduled. Staff members #1 and #2 reported that the Administrator was currently "in Phoenix."

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{A 033}	Continued From page 9	{A 033}		10/12/11
{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; (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	{A 033}		

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{A 033}	Continued From page 10 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 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;	{A 033}		10/12/11

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{A 033}	Continued From page 11 (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 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: This is a repeat deficiency from survey dated 12/14/2010	{A 033}		10/12/11

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{A 033}	Continued From page 12 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, observation and interview, the facility failed to ensure that a sufficient number of staff was provided to the population of this facility to meet minimum required staffing at night for 16 residents as well as avoid risky ongoing elopements for one (#1) of three (#1, 2 and 3) residents. The findings are: A. On 03/28/11 at 11:00 am, upon entry to the facility and during observation, there were two staff members present, Caregiver #1 and Caregiver #2. Caregiver #1 reported that there were currently 16 residents living in the facility. The licensed capacity of the building was 16 residents. Caregiver #1 was told that the visit was to conduct a re-visit for the December 2010 survey and follow-up on matters pertaining to the staffing situation. B. On 3/28/11 at around 11:05 am, during an interview Caregiver #1 reported that in accordance to the facility policy, the door alarm was to be off during the day shift and turned on at 6:00 pm. During that time, the door alarms were	{A 033}	7.8.2.33 (D) (11) A. The resident's rights have been reviewed and presented to all the residents in the facility. B. These rights will be given to and reviewed with all new residents coming into the facility. C. These rights will be reviewed with the residents on a yearly basis. D. Each staff member has been given a copy of the resident's rights and were inserviced on each right. E. The administrator and the assistant manager will monitor and implement on a yearly basis. Complete correction will be done by 10/17/11	10/12/11

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 _____	R-C 03/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY HOME INC	2021 BARBARA AVENUE GALLUP, NM 87301

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{A 033}	Continued From page 13 tested to ensure functionality of those alarms. Door alarms were noted to be functional when the switch was activated by staff inside the office. C. On 3/28/11 at 11:15 am, during an interview Caregiver #1 reported that earlier in the month, Resident #1 had eloped from the facility on foot and that police had to be called in order to locate him and bring him back to the facility. Review of Police report for case number 2001-00010747 indicates that a Missing Persons Incident was reported on Sunday 03/06/11 at 6:55 pm. The Missing Person was reported to be Resident #1 who was last seen at the facility. Significant to this incident as recounted in the police report, Caregiver #3 reported to police that only one staff member (Caregiver #3) was on shift when Dementia Resident #1 left the facility at around 6:20 pm. Caregiver #3 reported to the police that Resident #1 "has wandered off from the facility before on several occasions." The report also indicated that police officers then proceeded to look for the resident in the immediate area and were unable to locate him. D. On 03/28/11 at 12:00 pm, during record review of Resident #1's medical file indicated that he was a newer admission to the facility with an admission date of 01/06/11. Resident #1's assessment dated 01/07/11 indicated that he exhibits signs of forgetfulness, poor short term memory and was ambulatory with wandering behavior. Resident #1's physician orders dated 01/04/11 indicated a diagnosis of Rapidly Progressive Dementia. Resident #1's social history indicated that his elopement attempts arise as a result of his dementia and previous occupation as a sheepherder which apparently compelled him to attempt to look for his sheep. Review of the daily log for Resident #1 revealed	{A 033}		10/12/11

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(A D33)	Continued From page 14	(A 033)		10/12/11

that he attempted 3 elopements on 01/10/11, 1 attempt on 01/12/11, 1 attempt on 01/25/11, 1 attempt on 02/15/11 in which he jumped the facility fence and started running down the road, 1 attempt on 03/06/11, 1 attempt on 03/07/11 in which he again scaled the facility fence "like a deer" around 6:20 pm and the facility had to call the police to intervene and locate the resident, and 1 attempt on 03/09/11.

E. On 03/28/11 at 11:30 am, during an interview with Caregiver #1, she reported that the night shift from 12:00 am until 8:00 am the next morning was still being covered by only one staff member in spite of the fact that there were 16 residents in the building. Similarly, Caregiver #2 reported that during weekends, there was only one staff member present at that facility and available for the needs of the 16 residents. Both staff members reported that no additional staff had been hired so that two people could work the night shift or the weekend shift. Further review of schedules dated 03/06/11 through 04/02/11 revealed the same pattern of only one on site working staff for day shift on the weekends, and one night shift staff scheduled from 12:00 am until 8:00 am, seven days a week, leaving the facility chronically short staffed by 50% in accordance regulations when taking into consideration resident needs and resident census.

F. Record review of the staffing schedule for 03/28/2011, it was noted that the Administrator was scheduled on to work day shift.

G. On 03/28/11 at 11:40 am, during observation and interview, the Administrator was not present in the building at the time of the observetion as scheduled. Staff members #1 and #2 reported

Division of Health Improvement

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{A 033}	Continued From page 15 that the Administrator was currently "in Phoenix."	{A 033}	7 NMAC 8.2.13	10/12/11