STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5842	A. BUILDING: _____ B. WING _____	C 02/27/2013

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 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 000	Initial Comments A survey was completed for NMAC 7.8.2 regulations governing Assisted Living facilities for intake 28961. The complaint was substantiated with deficiencies cited.	A 000		
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.	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5842	A. BUILDING: _____ B. WING _____	C 02/27/2013

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 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 033	Continued From page 1 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 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	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5842	A. BUILDING: _____ B. WING _____	C 02/27/2013

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 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 033	Continued From page 2	A 033		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5842	A. BUILDING: _____ B. WING _____	C 02/27/2013

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 3 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 12/14/10, 02/06/13 and 02/27/13. Based on record reviews and interviews, the facility failed to protect the resident's right to prompt medical attention for 1 of 16 facility residents (Resident #1). The findings are: Facility daily log dated 01/16/2013 at 8-5 (shift) reads that Resident #1 fell while trying to back up (to the) chair, but Resident #1 said [redacted] okay just head that hurts when putting pressure to it. Facility daily log dated 01/21/2013 at 8-5 (shift) reads that during the previous night, Resident #1 fell for a second time in as many weeks. During a room check, Resident #1 was found with a very bloodied nose and unresponsive. Emergency medical services was called. Interviews with Caregiver #1 and Caregiver #2 on 2/27/2013 during the two o ' clock hour confirm that Resident #1 fell around 7:00am and that the ambulance was summoned after Caregiver #2 had left for the day, which was sometime after 8:00am.	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5842	A. BUILDING: _____ B. WING _____	C 02/27/2013

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 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 033	Continued From page 4 On 2/27/2013 at 2:42pm during interview with Caregiver #1 she reported that she did not witness the fall but found Resident #! around 7:15am. Caregiver #1 reports she was working in the kitchen making breakfast and was rounding residents up for breakfast when she saw the resident on the floor. Caregiver #1 reports that Resident #1 was responsive at that time. Caregiver #1 reports that she helped Resident #1 back to bed and cleaned up the blood. Caregiver #1 reports that after that " we let it (the situation) go " and later during medication pass at around 8:00am Resident #1 was again bleeding from the nose. Caregiver #1 reported that at that time, Emergency Medical Services was summoned. On 2/27/2013 at 3:00pm during interview with Caregiver #2 reported that she was attending Resident #2 when she saw Caregiver #1 outside Resident #1's room. Resident #1 was on the floor. She reports that Resident #3 and Caregiver #1 put Resident #1 back into the bed. Caregiver #2 reports that Resident #1 ' s nose was bleeding, but that Caregiver #1 was in charge and the decision to call Emergency Services was Caregiver #1. Caregiver #2 reports that she would not have moved Resident #1 and would have called 911. Caregiver #2 is currently attending nursing school. Review of the Call Report from local Law Enforcement Dispatch reveals that a call was made from the facility at 8:40am on 1/21/2013 to request Ambulance Service. The narrative reads that Resident #1 fell at 7:00am and was checked on at 8:00am and was found bleeding from the nose. Dispatch of Ambulance is documented at 8:43am, Ambulance arrival time documented at 8:49am, Arrival at the local hospital was documented to be 9:18am and Clear time (time	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5842	A. BUILDING: _____ B. WING _____	C 02/27/2013

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 5	A 033		

the call was cleared from the system) was 9:34am. Total time from dispatch to arrival at the hospital was about nine (9) minutes.

Historical medical visit dated 11/1/2010 reveals diagnoses for Resident #1 of status [redacted]

Medical Record from the local hospital dated 01/21/2013 reads that Resident #1 was brought to the emergency room at 9:21am from the facility due to unresponsiveness after a fall out of [redacted] wheelchair in which [redacted] hit [redacted] head, bled from the nose and was unresponsive. Notes reveal initial diagnosis of an [redacted] Resident #1 has fallen twice in the last two weeks at the group home.

Lab notes of Resident #1 's CT scan on 1/21/2012 at 1724 hours reveal a [redacted]

Hospital follow up progress notes dates 01/22/2013 at 14:56pm reveal that due to Resident #1' s condition a Skilled Nursing Facility will be considered at discharge. Later notes at 18:32pm in addition to the fall indicate Resident #1 was also found to have a [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5842	A. BUILDING: _____ B. WING _____	C 02/27/2013

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 6	A 033		

[redacted] Later that day at 22:20pm indicates that the functional assessment indicates that Resident #1 needed Total Assistance with all activities of daily living (ADLs) and was unresponsive to voice

Hospital follow up note dated 01/23/2013 reveals that Resident #1 was [redacted] Notes reveal that the mental state of Resident #1 was one of not appropriately responding to questions and pulling off [redacted] clothes.

History and physical dated 01/25/2013 by Resident #1's primary care physician reveals that Resident #1 suffered with [redacted]
Resident #1 medical history includes [redacted]

Nursing Admit Notes dated 01/25/2013 at 1726 from the local nursing home to which Resident #1 was admitted, revealed bruising on the arms and lower front extremities as well as bruises on the left (L) side of the head and left (L) shoulder. The admitting diagnosis for Resident #1 was [redacted]

Progress Notes from the nursing home admission dated 01/25/2013 at 1726 revealed that Resident #1 was admitted with bruises to extremities and the left (L) side of the head and [sic] that admission is for comfort measures only.
Progress Notes from the nursing home dated [redacted]/2013 reveals that Resident #1 is [redacted] Progress Notes from the nursing home dated 01/30/2013 - 02/02/2013 reveals that Resident #1 remained on comfort measures at the nursing home. Ultimately, Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5842	A. BUILDING: _____ B. WING _____	C 02/27/2013

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 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 033	Continued From page 7 passed away at the local nursing home on 02/03/2013 at 2055.	A 033		