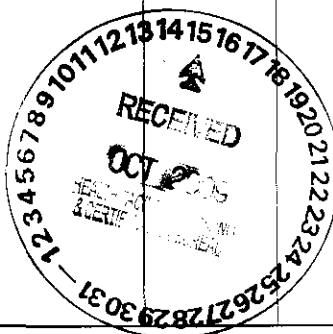


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5842	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/01/2009
NAME OF PROVIDER OR SUPPLIER BONNEY HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 01	OPENING REMARKS Complaint #NM00027280 - Unsubstantiated	A 01			

*Scanned
10/26/09
JH*



Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE *Director*

(X6) DATE

STATE FORM

6899

15KY11

If continuation sheet 1 of 1