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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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 01	OPENING REMARKS Surveyor: 20402 The following deficiencies were cited during a complaint investigation conducted on 5/25/07. Complaint NM23760 was investigated and deficiencies were cited.	A 01		
A17	7 NMAC 8.2.17 PERSONNEL 7.8.2.17 PERSONNEL: The adult residential care facility must have and implement written personnel policies. The personnel policies must address the following: A. Qualifications for all professional and non-professional disciplines. B. Staff conduct which must foster resident safety and well-being and must not be detrimental to resident care. C. Staff training, appropriate to staff responsibilities, including, at a minimum, an orientation and an on-going, but at least annual, program which includes: Fire Safety, First Aid, Safe Food Handling practices, Confidentiality of Records and Resident information, Infection Control, Resident Rights, Reporting Requirements for Abuse, Neglect, and Exploitation, Transportation Safety for Assisting residents and operating vehicles to transport residents and Providing Quality Resident Care based on current resident needs. D. Employee personnel records, including an application for employment, TB tests and certificates, training records, and personnel actions. [4-7-97; 7.8.2.17 NMAC - Rn & A, 7 NMAC 8.2.17, 8-31-00] This REQUIREMENT is not met as evidenced by:	A17		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Tiwanna Bonney 8/8/07

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A17	Continued From page 1 Surveyor: 20402 Refer to 7.8.2.17 Based on record review and interview, the facility failed to have 2 of 4 employee personnel records which contained current orientation and annual on-going training and in-services to include: Fire Safety, First Aid, Safe Food Handling, Confidentiality of Records, Infection Control, Resident Rights, and Reporting Requirements for Abuse, Neglect, and Exploitation. The findings are: A. On 5/25/07 at 11:15 a.m. review of the employee personnel files revealed the following: a. Employee #2 was hired on 9/17/06 and the orientation and Inservice form was blank. No documentation indicated that this employee had a general orientation or any on-going inservices. b. Employee #3 was hired on 2/1/01. Review of the Orientation and Inservice form indicated that this employee did not receive a general orientation when hired in 2001. B. On 5/25/07 at 11:15 during interview, Employee #4 stated, "the trainings and inservices are done every month. I do the orientations for two weeks before they go on their own then one month later, I do the trainings." C. On 5/25/07 at 12:25 p.m. during interview, the Owner of the facility stated, "yes, I've been doing the inservices every six months. They are done once they are hired, then every six months."	A17	A17A Employee 2 Updated in-service was completed by Juliana Bonney on May 26, 2007. See attachment for copy 05/26/07 Employee 3 Updated in-service was completed by Juliana Bonney on May 26, 2007. See attachment for copy. 05/26/07 B Employee #4 Updated in-service was completed by Juliana Bonney on May 26, 2007. See attachment for copy. 05/26/07 B. Director will check every 3 months the employee folder to ensure all in-service is updated and on time. C. This was completed on 05/26/07	
A23	7 NMAC 8.2.23 FAC. REPORTS,RECS.,P & PS & RULES 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND	A23		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A23	Continued From page 2 PROCEDURES/ AND RULES: A. REPORTS AND RECORDS: Each facility must keep the following reports, records, and policy and procedures on file at the facility and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or appeals thereto, and complaints. (3) Copy of the latest survey from Environmental Health Authority (if applicable) regarding kitchen and food management and, if private sewage disposal, and private waste disposal. EXCEPTIONS: Adult residential care facilities with three (3) or fewer residents are not required to be inspected by Environmental Health Authority. Facilities exempted by the Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file. (4) TB test results of staff or any of their family members living in the facility. (5) One (1) month of menus planned and as served. (6) Record of fire drills: A record of all fire drills conducted at the facility. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to hold or record fire drills. (7) Written emergency plans and policies and procedures for medical emergencies, power failure, fire or natural disaster. Such plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes and refuge areas, responsibilities of personnel.	A23		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A23	Continued From page 3 (8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC). (9) Custodial Drug Permit: A valid Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit. (10) Vaccination of pets in the facility. (11) Staff training. (a) At orientation and on-going. (b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...) (c) Fire safety. (d) First aid. (e) Safe food handling practices. (f) Confidentiality of records and resident information. (g) Infection control (including universal precautions and linen handling). (h) Resident rights. (i) Providing Quality Resident care based on current resident need. (j) Reporting requirements for Abuse, Neglect or Exploitation. (12) A copy of License. (13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions. (14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority. (15) A copy of the floor plans as approved for licensure. B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules	A23		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A23	Continued From page 4 pertaining to but not limited to the following: (1) The use of tobacco and alcohol. (2) The use of the telephone. (3) Operation of television, radio, and stereo. (5) Use and safekeeping of personal property. (6) Meals. (7) Use of common areas. (8) Electric blankets or appliances used by residents. C. POLICIES AND PROCEDURES: All facilities shall have written policies and procedures covering the following areas: (1) Actions to be taken in case of accidents or emergencies, (e.g., gas leaks, injuries, transportation, medications,...). (2) Method of keeping informed when residents go outside of the facility (e.g., sign-out sheets). (3) The handling or resident's funds, if the facility provides such services. (4) Reporting of incidents, including abuse, neglect, and exploitation. (5) Handling of complaints. (6) Staff and resident fire and safety training. (7) Smoking. (8) The facility's bed hold policy. (9) Admission agreement. (10) Admission records. (11) Resident records. (12) Program Narrative. (13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (14) Personnel policies. (15) Identifying and safeguarding resident possessions.	A23		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A23	Continued From page 5 (16) Securing medical assistance if a resident's own physician is not available. (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles. (19) Staff training for employees who operate motor vehicles to transport residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.23 NMAC - Rn & A 7 NMAC 8.2.23, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Refer to 7.8.2.23 A (11) (13) Based on record review and interview the facility failed to have 2 of 4 employee personnel records which contained current orientation and annual on-going trainings and in-services to include: Fire Safety, First Aid, Safe Food Handling, Confidentiality of Records, Infection Control, Resident Rights, and Reporting Requirements for Abuse, Neglect, and Exploitation. The findings are: A. On 5/25/07 at 11:15 a.m. review of the employee personnel files revealed the following: a. Employee #2 was hired on 9/17/06 and the orientation and Inservice form was blank. No documentation indicated that this employee had a general orientation or any on-going inservices. b. Employee #3 was hired on 2/1/01. Review of the Orientation and Inservice form indicated	A23	A23 A - Division of Health Inspection report for the last reporting period was posted on the bulletin board located in the dining room. It has been removed by an unknown person. The staff member could not tell me who removed the report. It is now lost. B. In the future, the Director will post a copy of her copy of the Division of Health Inspection report on the bulletin board and will check every week to see it is still posted. C. This was corrected on August 3, 2007 when it was brought to Director's attention. Correction made on 08/03/07	

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A23	Continued From page 6 that this employee did not receive a general orientation when hired in 2001. B. On 5/25/07 at 11:15 during interview, Employee #4 stated, "the trainings and inservices are done every month. I do the orientations for two weeks before they go on their own then one month later, I do the trainings." C. On 5/25/07 at 12:25 p.m. during interview, the Owner of the facility stated, "yes, I've been doing the inservices every six months. They are done once they are hired, then every six months."	A23		
A26	7 NMAC 8.2.26 RESIDENT ASSESSMENT 7.8.2.26 RESIDENT ASSESSMENT: A. A resident assessment to determine level of function and if the client's needs can be met by the facility. The initial assessment must be completed within five (5) days of admission and reviewed every six (6) months as part of the individual service plan. B. The resident assessment must establish a baseline in the resident's functional status and thereafter, identify resident changes through periodic reassessments. C. The resident assessment must be documented on a state approved resident assessment form and at a minimum include the following: (1) Cognitive patterns. (2) Communication/hearing patterns. (3) Vision patterns. (4) Physical functioning and structural problems. (5) Continence. (6) Psycho social well-being. (7) Mood and behavior patterns. (8) Activity pursuit patterns.	A26		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A26	Continued From page 7 (9) Disease diagnoses. (10) Health conditions. (11) Oral/nutritional status. (12) Oral/dental status. (13) Skin conditions. (14) Medication use. (15) Special treatment and procedures. D. The resident admission assessment, the physical exam report, and the observation and evaluation of staff with regards to the needs will be used to develop the individual service plan, if needed. If the resident assessment does not indicate a need for an individual service plan, then an individual service plan is not required. However, an individual service plan must be prepared for residents requiring nursing services. [4-7-97; 7.8.2.26 NMAC - Rn, 7 NMAC 8.2.26, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Refer to 7.8.2.26 Based on record review and interview the facility failed to ensure that 13 of 15 sampled resident assessments (R#1,2,3,4,5,6,7,8,9,10,11,14,15) were being reviewed every six (6) months. The findings are: A. On 5/25/07 at 9:45 a.m. review of the following sampled residents records revealed the following: 1. Resident #1's last individual assessment was completed on 10/23/06. No current assessment for 2007 was located in the resident's record. 2. Resident #2's last individual assessment was completed on 9/22/06. No current assessment for 2007 was located in the resident's record. 3. Resident #3's last individual assessment	A26	A26 A1 - Residents1 Resident 1 - Assessment has been done and updated. Juliana Bonney completed assessment and placed it in resident's folder on 05/27/07. See attachment as copy. A2. Resident 2 Resident 2 - Assessment has been done and updated. Juliana Bonney compl ted assessment and placed it in resident's folder on 05/27/07. See attachment as copy. A3. Resident 3 Resident 3 - Assessment has been done and updated. Juliana Bonney completed assessment and placed it in resident's folder on 05/27/07. See attachment as copy. A4. Resident 4 Resident 4 - Assessment has been done and updated. Juliana Bonney completed assessment and placed it in resident's folder on 05/27/07 See attachment as copy. A5. Resident 5 Resident 5 - Assessment has been done and updated. Juliana Bonney completed assessment and placed it in res dent's folder on 05/27/07 See attachment as copy.	

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A26	Continued From page 8 was completed on 7/5/06. No current assessment for 2007 was located in the resident's record. 4. Resident #4's last individual assessment was completed on 7/22/06. No current assessment for 2007 was located in the resident's record. 5. Resident #5's last individual assessment was completed on 6/19/06. No current assessment for 2007 was located in the resident's record. 6. Resident #6's last individual assessment was completed on 6/22/06. No current assessment for 2007 was located in the resident's record. 7. Resident #7's last individual assessment was completed on 6/8/06. No current assessment for 2007 was located in the resident's record. 8. Resident #8's last individual assessment was hand written 7/22/06 but an additional assessment had a hand written date of 6/26/06 on it. It was unclear as to when the last assessment was completed. 9. Resident #9's last individual assessment was completed on 7/22/06. No current assessment for 2007 was located in the resident's record. 10. Resident #10's last individual assessment was completed on 8/7/06. No current assessment for 2007 was located in the resident's record. 11. Resident #11's last individual assessment was completed on 6/24/06. No current assessment for 2007 was located in the resident's record. 12. Resident #14 and 15's last individual assessment were completed on 8/7/06. No current assessments for 2007 was located in the resident's records. B. On 5/25/07 at 10:45 a.m. during interview, the owner of the facility stated, "yes, I do the	A26	A26 6A - Resident 6 Resident 6 - Assessment has been done and updated. Juliana Bonney completed assessment and placed it in resident's folder on 05/27/07. See attachment as copy. 7A - Resident 7 Resident 7 - Assessment has been done and updated. Juliana Bonney completed the assessment and placed it in resident's folder on 05/27/07. See attachment as copy. 8A - Resident 8 Resident 8 - Assessment has been done and updated. Juliana Bonney completed the assessment and placed it in resident's folder on 05/27/07. See attachment as copy. 9A - Resident 9 Resident 9 - Assessment has been done and updated. Juliana Bonney completed the assessment and placed it in resident's folder on 05/27/07. See attachment as copy. 10A - Resident 10 Resident 10 - Assessment has been done and updated. Juliana Bonney completed the assessment and placed	

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A26	Continued From page 9 assessments and ISP's every six months, then I have my nurse come in to sign off on them. It's a work in progress, you just happened to get here before we could do it."	A26	A27 A 1 - Resident 1 Resident 1 - ISP has been updated by Juliana Bonney on 05/27/07 and the registered Emma Eriacho signed on it. A copy is in place in resident's folder. See attachment as copy. A 2- Residents 2-4 Resident 2 - ISP has been updated by Juliana Bonney on 05/27/07 and the registered nurse Emma Eriacho signed on it. A copy is in place in resident's folder. See attachment as copy. Resident 4 - ISP has been updated by Juliana Bonney on 05/27/07 and the registered nurse Emma Eriacho signed on it. A copy is in place in resident's folder. See attachment as copy A 3 - Resident 3 - ISP has been updated by Juliana Bonney on 05/27/07 and the registered nurse Emma Eriacho signed on it. A copy is in place in resident's folder. See attachment as copy A 4 - Residents 5 - 7 Resident 5 - ISP has been updated by Juliana Bonney on 05/27/07 and the registered nurse Emma Eriacho signed on it. A copy is in place in resident's folder. See attachment as copy	
A27	7 NMAC 8.2.27 INDIVIDUAL SERVICE PLAN 7.8.2.27 INDIVIDUAL SERVICE PLAN: A. An individual service plan, if prompted by the resident assessment, shall be developed and implemented within fourteen (14) days of admission, and must address those areas of need as identified in the resident assessment. The individual service plan must be reviewed by a licensed nurse at least every six (6) months, and revised as needed at the time of each assessment and consistently implemented in response to the resident's needs. B. The individual service plan must include the following: (1) Description of identified needs as noted in the resident assessment. (2) Written description of what services will be provided. (3) Who will provide the services. (4) When or how often the services will be provided. (5) How the services will be provided. (6) Where the services will be provided. (7) Goal and outcome of the service. (8) Documentation of the facility's determination that it is able to meet the needs of the resident.. [7-11-86, 1-11-90, 4-7-97; 7.8.2.27 NMAC - Rn, 7 NMAC.8.2.27, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Refer to 7.8.27 A.	A27		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A27	Continued From page 10 Based on record review and interview, the facility failed to have 14 of 15 sampled residents (R#1-15, excluding sampled resident #12) Individual Service Plans reviewed every six months by a licensed nurse. The findings are:. A. On 5/25/07 at 9:45 a.m review of residents (R#1-15) records revealed the following: 1. Resident (R#1's) ISP (Individual Service Plan) had no date or signature as to when the ISP was completed. A second ISP was located with a handwritten date of 8/7/06. No current ISP for 2007 was located. 2. Resident (R#2,4) ISP's were dated 7/22/06. No current ISP's for 2007 were located in the resident's records. 3. Resident (R#3's) ISP was dated 7/5/06. No current ISP for 2007 was in the resident's record. 4. Residents (R# 5,7) ISP's were dated 6/19/06. No current ISP's for 2007 were located in the resident's records. 5. Resident (R#6) ISP was dated 3/22/06. No current ISP for 2007 was in the residents record. 6. Resident (R#8) ISP was dated 5/10/05. No current ISP for 2007 was in the residents record 7. Resident (R#9) ISP was dated 7/21/06. No current ISP for 2007 was in the residents record. 8. Residents (R# 10,14) ISP's were dated 8/7/07. No current ISP's for 2007 were located in the resident's records. 9. Resident (R#11's) ISP was dated 6/24/06. No current ISP for 2007 was in the residents record. 10. Resident (R#13's) ISP did not have a date on it as to when it was completed. 11. Resident (R#15) ISP was dated 2/7/06. No current ISP for 2007 was in the residents record.	A27		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A27	Continued From page 11 B. On 5/25/07 at 10:45 a.m. during interview, the owner of the facility stated, "yes, I do the assessments and ISP's every six months, then I have my nurse come in to sign off on them. It's a work in progress, you just happened to get here before we could do it."	A27		
A36	7 NMAC 8.2.36 MEDICATIONS 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws. A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. C. No medications, including over the counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order by the physician and entry into the resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects. E. Medications prescribed for one resident shall not be used for another resident.	A36		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A36	Continued From page 12 F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include: (1) Name of resident. (2) Date started. (3) Drug product name. (4) Dosage and form. (5) Strength of drug. (6) Route of administration (e.g. "by mouth"). (7) How often medication is to be taken. (8) Time taken and staff initials. (9) Dates when the medication is discontinued or changed. (10) The name and initials of all staff administering medications. G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting. H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions: (1) The resident is capable of determining when the medication is needed. (2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include: (a) Symptoms that might indicate the use of the medication. (b) Exact dosage to be used. (c) The exact amount of medication to be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist.	A36	A36 A. - The Director went through all medication for these res dents and has compared what is written on the bottles is what is on the MAR to ensure it is written correctly. Also all medication has been listed on MAR. B. Staff member who did not have medication training was moved June 1, 2007 to the westside facility. She has been given a verbal warning not to touch any medication until she passes her test. She did not past her test the first or second time she took it. The Director is going to work with staff member step by step again to prepare her for the third test. Also in the meeting held on May 26, 2007 all staff members were instructed not to keep pre-poured medication in advance. Anyone who disobeys this instruction will be reprimanded or terminated. C. This was corrected on 05/26/07	

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A36	Continued From page 13 (e) Possible interactions or side-effects that might occur. (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Refer to 7.8.2.36 C, F Based on record review and interview, the facility failed to ensure the following: a) that no medications be started, changed, or discontinued by the facility without an order by the physician for 3 of 15 sampled residents (R#5,6,8) and b) the Medication Administration Record (MAR) documentation was accurate. The findings are: A. On 5/25/07 at 9:45 a.m. when comparing residents medications to the MARS (Medication Administration Records) the following discrepancies were noted for residents (R#5,6,8) 1. Resident #5's Medication box contained Seroquel 25 mg tablets. Two remaining pills were observed in bubble packaging. When it was compared to the May 2007 MAR, this medication was not listed on the MAR. Review of a physicians order dated 5/22/07 does not list a dosage of Seroquel, time, or amount to be administered. a. An additional medication located in the medication box was Phenytoin 50 mg chewable tablets. The bottle reads: Take 1 tablet	A36	A36 A1 - The resident's medication was ordered 07/11/06. A copy of that order is attached. A36 B - The resident's medication is recorded on the MAR and will remain on the MAR. Juliana Bonney has talked to Maria Lopez who is in charge of the prescription log-in and also to make sure all the residents medication has been recorded on the MAR. A36 C - This was completed	05/26/07

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A36	Continued From page 14 chew/swallow by mouth at bedtime. b. A second bottle of Phenytoin Sodium ER 100 mg caps was located in the same medication box. The label on the bottle read: Take 2 capsules by mouth at bedtime. c. Both of these medications were in the medication box with the other medications. When both of theses medications were compared to the MAY 2007 MAR, the hand written dosage on the MAR listed Phenytoin NA (50 mg) extended swallow. Take 3 capsules at bedtime every night. d. When the physicians orders were reviewed, it was noted that a physicians order dated 5/22/07 lists Phenytoin and Phenytoin Sodium ER (but no dosages, how many, and how often to take is indicated on the orders.) Review of a previous physicians order dated 2/28/07 lists Phenytoin NA 100 mg on the order. 2. Resident #6's Medication box contained 1 empty bottle of Furosemide 20 mg. The bottle read take 1/2 tablets by mouth every morning for excess fluid. When it was compared to the MAR, this medication was not listed on the MAR. When this was compared to the physicians orders, no order could be located indicating dosage, how often, or amount to be taken. a. An additional bottle of Triamterene/HCTZ 75 mg was located in the medication box. The bottle read take HCTZ 1/2 tab by mouth for high BP. When this medication was compared to the MAR, the hand written dosage on the MAR read HCTZ 25 mg. When this medication was compared to a Physicians order dated 4/11/07, it indicated the HCTZ to be 25 mg not 75 mg. 3. Resident #8's Medication box contained one bottle of Simvastatin 40 mg tab. The bottle reads take 1 tab by mouth at bedtime. When	A36	A36 2. - There was a record of doctor's orders in resident #6 folder which may have been an oversite. We have a new order dated May 30, 2007 in place in resident's folder. A copy is attached. B. The Director will take measures to keep this from happening in the future. C. This was corrected	05/30/07
			A36 3. - Resident 8 Medication was initially ordered at 80mg. On 04/12/07 according to the pharmancy list on his medication was changed to 40mg but the facility did not have a copy of the doctor's orders until 5/25/07 at 10:00 a.m. B. A copy of the pharmancy list and doctor's orders is attached. The Director will take the measure to see if medication has changed and get new doctor's orders when resident is taken for his appointments. C. This was corrected	05/25/07

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A36	Continued From page 15 compared to the MAR, the hand written dosage on the MAR reads Simvastatin 80 mg take 1/2 tablets at bedtime. Review of a physicians order dated 5/19/07 reads Simvastatin 80 mg. The physicians order does not indicate to take 1/2 tablet. a. An additional physicians order for Lactulose 10 mg was located, and was listed on the MAR, but no medication was located in the Medication box. B. On 5/25/07 when a state surveyor was comparing the resident's medications to the MARS with Employee #4 and the facility owner, both confirmed that either no physicans orders could be located or that the medication that was listed on the MARS, differed to what the physicains orders indicated, and additionally some medications had differnt doses to what was either on teh medication bottles, or physicians orders. C. On 5/30/07 at 10:45 a.m. during interview with the facilities Consultant Pharmacist, he stated, that he went out to the facility yesterday (5/29/07) and had the following concerns: staff not getting rid of discontinued medications that are taken out of the medication cabinet, meds not being labeled, poor record keeping and not accounting for all controlled substances, and being difficult for the consultant pharmacist to reconcile the MARS and physician orders.	A36		
A38	7 NMAC 8.2.38 FOOD MANAGEMENT 7.8.2.38 FOOD MANAGEMENT: Each facility must store, prepare, distribute and serve food under sanitary conditions and in accordance with the New Mexico Environment Department Food Service and Processor Regulations, if applicable.	A38		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A38	Continued From page 16 A. Each facility shall ensure a minimum of a three (3) day supply of perishable and a five (5) day supply of non-perishable or canned food is provided for the residents. B. All milk, to include dry milk products, shall be Grade A pasteurized. C. Potentially hazardous food such as meat, milk, and custard shall be kept at 45 degrees F or below or at 140 degrees F or above. D. Each refrigerator and freezer shall be provided with an indicating thermometer accurate to plus or minus 3 degrees F, located in the warmest section of the refrigeration facility and must be of such type and so situated that the thermometer can be easily read. Thermostats shall not be relied upon to maintain temperatures at correct levels in the absence of thermometers. The temperature of the refrigerator shall be 35 degrees F- 45 degrees F. Freezer temperatures shall be maintained at 0 degrees F or below. E. Refrigerators, freezers, kitchen area and food preparation areas shall be kept clean and sanitary at all times. Food stored in refrigerators/freezers shall be covered, dated, and labeled. Unused leftover food shall be discarded after three days. F. Medication, biological, poisons, detergents, and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications may be stored in the refrigerator with food, if they are labeled and locked in a container marked specifically for medication. G. Dishes, utensils, and preparation equipment shall be properly washed and stored to maintain sanitary conditions. H. All garbage and rubbish shall be stored in containers which are waterproof, easily cleaned and have tight fitting lids. Food waste containers shall be kept in good repair, and shall be kept	A38	A38 A. - The manager buys salad dressing and mustard in large cans. The bottles are washed and sanitized when emptied and then refilled with the new contents. Also frozen bags have been washed and sanitized before they are filled with new contents. During inspection, all food items listed were removed and thrown away in fron of the inspector. B. A meeting was held on May 25, 2007 with the staff members and instru ted them not to continue refilling the bottles and frozen ags but to use new which have expiration date stamped on them. The Director will go in the pantry every 30 days to make sure that the food items within useable expiration dates are available and expired items are thrown away. C. This was corrected on 05/27/07	

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A38	Continued From page 17 covered except during use. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 4-7-97; 7.8.2.38 NMAC - Rn, 7 NMAC 8.2.38, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Refer to 7.8.2.38 Based on observation and interview, the facility failed to ensure that food in the refrigerator/freezer/ and pantry was covered, dated, and properly labeled. The facility also failed to ensure that all unused leftover food was discarded after three days. The findings are: A. On 5/23/07 at 5:00 p.m. during interview, an Ombudsman representative from Aging and Long Term Services stated that the first time she went out to the facility on May 3, 2007 she pulled out a can of food that was dated from 1999. The Ombudsman representative also stated that on May 3, 2007 Employee #4 assured her that she would take out all expired cans of food. The Ombudsman Representative also stated that when she went to visit the facility, she observed opened bags on flour which were not in containers, and 5 heads of cabbage that were rotting in th refrigerator. B. On 5/25/07 at 8:33 a.m. observation of the facilities kitchen revealed the following: 10 large pieces egg plant sitting on a large box in a opened white garbage bag. The bag has no date or label on it and the egg plate is observed as bruised and squishy. 1 large box filled with approximately 50 cucumbers which were bruised and squishy. Some of the cucumbers were observed with	A38		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A38	Continued From page 18 white mold that was on tips and surfaces. 1 approximately 50 lb bag of potatoes located under a fire extinguisher. This bag is open and not dated and the potatoes are bruised, squishy and have a strong odor coming from the bag. The potatoes are observed with a white mold on them. 1 approximately 50 lb bag of carrots that is opened, not dated, or labeled. The carrots are observed as squishy with some having black tips on them. C. On 5/25/07 at 8:40 a.m. observation of a non-working Jackson Conserver LT Dishwasher revealed the following items inside the dishwasher: 1 opened box Macaroni & Cheese 1 6 oz box Quick/easy Shake N' Bake Original Pork. The date on the box reads: Exp 27, Jul 04 Multiple crumbs of leftover food and two old pieces of Tupperware dishes D. On 5/25/07 at 8:45 a.m. observation of a large cabinet located next to the kitchen oven revealed 1 pkg of low-fat Stoned Wheat Crackers. The lid of the box is opened and the expiration date on the box reads: Use by Sept. 05. E. On 5/25/07 at 8:50 a.m. observation of the facilities Refrigerator revealed the following items: 1 30 oz. white container filled with a meat substance with gravy. There is a strong odor that is observed from the container and date or label on the container. 1 25 fl oz. Marie's Chunky Blue Cheese Dressing. The label on the bottle reads Dec 16, 2006 1 Quart Lucerne Reduced Fat Buttermilk, that is opened and the date on the Quart reads:	A38		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A38	Continued From page 19 Sell by April 9. 1 Quart 100% Lactose Free Fat Free Milk-Ultra Pasturized. The date on the label reads sell by April 15,07 1 1.5 fl oz. Marie's Honey Dijon Dressing. The expiration date on the bottle reads: Dec 17, 06 1 small white container filled with rice, gravy, and meat. No date or label is on the container. 1 bag Fresh Express Spring Mix Salad. The expiration date on the bag reads May 06. 1/2 Hickory Farm Beef Stick in a large clear plastic baggy with no date or label. 1 brown squishy head of lettuce F. On 5/25/07 at 9:10 a.m. observation of the facilities Freezer revealed the following items: 1 opened bag of frozen bacon that is not labeled. The date on the pkg reads Feb 18,06 1 large bag full of frozen chicken legs. No date or label on on the bag and frost could be seen on the chicken legs. G. On 5/25/07 at 9:15 a.m. observation of the facilities Pantry revealed the following items: 1 3 oz. potted meat food product. The expiration date on the container reads: best by march 06 1 Homepride Korma Cook-in-sauce. The date on the container reads June 2005 1 14.5 oz. can whole peeled tomatoes. The date on the container reads: best by Dec 2004. H. On 5/25/07 at 9:45 a.m. during interview, when Employee#4 was questioned about the box of cucumbers, potatoes, and carrots that were located in the kitchen, this employee stated that "we do use the potatoes in the large bag as well	A38		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A38	Continued From page 20 as the cucumbers and carrots. What we don't use, I'll give to the other house." I. On 5/25/07 during a complaint investigation, as a state surveyor was asking both Employee #4 and the owner of the facility both individuals acknowledged that food was either outdated, and not labeled.	A38		
A39	7 NMAC 8.2.39 HOUSEKEEPING/LAUNDRY SERVICES 7.8.2.39 HOUSEKEEPING/LAUNDRY SERVICES: The adult residential care facility shall maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. The facility must be free from offensive odors, safety hazards, insects and rodents, and accumulations of dirt, rubbish, dust. A. Bathrooms and all common living areas must be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags and compounds shall be stored in closed metal containers in approved areas providing adequate ventilation. Combustibles shall be stored away from the food preparation area and away from resident rooms. C. Poisonous or flammable substances must not be stored in residential areas, food preparation areas, or food storage areas. D. The adult residential care facility shall make available laundry services to the residents either on the premises or by use of a commercial laundry or linen service. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (1) All linens shall be changed as needed and at least weekly. (2) The mattress pad, blankets, and	A39		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A39	Continued From page 21 bedspread shall be laundered as needed and at least once a month. (3) Bath linens consisting of face towel, bath towel and wash cloth shall be changed as needed and at least three (3) times per week. (4) Residents shall have clean clothing as needed to maintain dignity and be free of odors. E. Laundry services provided on the premises shall have a designated laundry area equipped with a washer and dryer. F. Under no circumstances shall collection, sorting, storage or washing of soiled clothing or linen be done in a food preparation, food storage, or food service area. G. Residents may do their own laundry if they are capable and WISH to do so, or if it is part of a training or rehabilitation program specifically documented in the resident's individual service plan. H. A separate, dry, well ventilated storage area for clean linen shall be provided. [7-1-64, 9-15-70, 5-26-72, 7-19-74, 9-24-76, 7-11-86, 4-7-97; 7.8.2.39 NMAC - Rn, 7 NMAC 8.2.39, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Refer to 7.8.2.39 Based on observation and interview the facility failed to ensure that one residents bathroom was clean, and sanitary. The findings are: A. On 5/25/07 at 8:25 a.m. during initial tour of the facility, the following was noted in one bathroom that was connected to resident (R#12's) bedroom in which this resident uses: 1. An approximately 3 inch smear of dried dark brown fecal matter located on the wall of the	A39	A39 The toilet seat in resident's bedroom was replaced by Derrick Fortney on May 25, 2007. When it was discovered there was no toilet paper in bathroom, it was placed in resident's bathroom immediately for resident's use. B. During the meeting with staff members the next day, they were instructed to check all bathroom and toilet areas to make sure toilet paper has been adequately placed. The Director will make sure this will not happen again. Also, will monitor every day. C. This was corrected	05/15/07

2 x day.

Toni Pettigrew 5-26-07
Bertha Blackgoat "
Willie Allison - "
Maria Lopez
Laverne Tom
Juliana Bonany

Staff meeting to discuss the State findings from Thursday and Friday May 24 and 25th

Topic are medications, and medicatic orders from the doctors, members of the staff need to make sure that a changes has been writting before the bring resident from the hopital and if the doctor calls about the changes in residence medication they need to make sure they go to the clinic and pick up the orders. Also food that ~~has~~ comies from the groecery store, we need to used the old date before we use the new items. Do not reused the old cont any more.

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A39	Continued From page 22 bathroom and a additional 1 inch smear next to it. 2. The resident's toilet was broken and a large visible crack could be seen on the left upper side of the toilet. 3. There was no toilet paper available for the resident to use. a. a second observation was conducted at 9:30 a.m. after which the housekeeping staff had finished cleaning the area to the bathroom. The same 3 inch smear of dried dark brown fecal matter located on the wall was still there, as well as the cracked toilet, and no toilet paper on the roller. B. On 5/25/07 during interview (no time indicated) Employee #4 stated, that the cleaning person comes in frequently and confirmed that resident (R#12) does use her own bathroom.	A39		
A56	7 NMAC 8.2.56 TOILET AND BATHING FACILITIES 7.8.2.56 TOILET AND BATHING FACILITIES: A. A minimum of one (1) toilet, one (1) sink and one (1) bathing unit must be provided for every eight (8) residents or fraction thereof. Each facility shall provide at least one tub and one shower or combination unit to allow for residents bathing preference. B. The combination type tub and shower is permitted. C. toilets, tubs, and showers must be provided with grab bars. D. If a facility has live in staff, a separate toilet, sink, and bathing facility must be provided. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a separate toilet, sink, and bathing facility for live in staff. E. Tubs and showers must have a slip	A56		

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A56	Continued From page 23 resistant surface. F. Toilet, sink, and bathing facilities must be readily available to the residents. No passage through a resident room by another resident to reach a toilet, bath, or sink facility is permitted. G. All facilities must have a minimum of one (1) toilet and bathing facility which meets requirements for the disabled. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a toilet and bathing facility which meets requirements for the disabled. H. Toilet paper and soap must be provided in each toilet room. I. The use of a common towel is prohibited. J. Bathrooms and lavatories must be cleaned as often as necessary to maintain a clean and sanitary condition. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.56 NMAC - Rn, 7 NMAC, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Refer to 7.8.2.56 Based on Observation and interview the facility failed to ensure that a residents bathroom was clean as often as necessary to main a clean and sanitary condition. The facility also failed to ensure that all bathrooms had toilet paper in each toilet room. The findings are: A. On 5/25/07 at 8:25 a.m. during initial tour of the facility, the following was noted in one bathroom that was connected to resident (R#12's) bedroom in which this resident uses: 1. An approximately 3 inch smear of dried dark brown fecal matter located on the wall of the bathroom and a additional 1 inch smear next to it.	A56	A56 C. A phone call was made to the property owner, Jack Fuhs on August 3, 2007. He indicated that he would send somebody to look at the bathroom stall to see what could be done about installing a door. B. I will continue to check with Mr. Fuhs on a weekly basis to inquire as to the progress of getting a door on this bathroom stall. C. Completed on 08/03/07	

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 05/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNEY FAMILY 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
A56	Continued From page 24 2. The resident's toilet was broken and a large visible crack could be seen on the left upper side of the toilet. 3. There was no toilet paper available for the resident to use. a. a second observation was conducted at 9:30 a.m. after which the housekeeping staff had finished cleaning the area to the bathroom. The same 3 inch smear of dried dark brown fecal matter located on the wall was still there, as well as the cracked toilet, and no toilet paper on the roller. B. On 5/25/07 during interview (no time indicated) Employee #4 stated, that the cleaning person comes in frequently and confirmed that resident (R#12) does use her own bathroom. C. On 5/25/07 during observation (no time indicated) it was noted that the large bathroom located on the left side of the hallway where male and female residents frequently use, had no door on the first bathroom stall for privacy and also had no toilet paper on the roller for the duration of the complaint investigation. Residents were observed as using this bathroom, going into the stall without a door, and having no toilet paper.	A56		