

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
--------------------------------------------------	----------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 5/24/2007.	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: Surveyor: 20402 Refer to 7.8.2.17	A17		

Division of Health Improvement

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

TITLE _____ (X6) DATE 8/8/07
Jill Bonney

STATE FORM

6899

F10L11

If continuation sheet 1 of 23

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 2 remember."	A17		
A23	7 NMAC 8.2.23 FAC. REPORTS, RECS., P & PS & RULES 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND 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.	A23		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
--------------------------------------------------	-----------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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	<p>Continued From page 3</p> <p>(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.</p> <p>(8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC).</p> <p>(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.</p> <p>(10) Vaccination of pets in the facility.</p> <p>(11) Staff training.</p> <p>(a) At orientation and on-going.</p> <p>(b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...)</p> <p>(c) Fire safety.</p> <p>(d) First aid.</p> <p>(e) Safe food handling practices.</p> <p>(f) Confidentiality of records and resident information.</p> <p>(g) Infection control (including universal precautions and linen handling).</p> <p>(h) Resident rights.</p> <p>(i) Providing Quality Resident care based on current resident need.</p> <p>(j) Reporting requirements for Abuse, Neglect or Exploitation.</p> <p>(12) A copy of License.</p> <p>(13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions.</p> <p>(14) A copy of all WAIVERS/VARIANCES</p>	A23	<p>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.</p> <p>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.</p> <p>C. This was corrected on August 3, 2007 when it was brought to Director's attention</p> <p style="text-align: right;">Correction made on 08/03/07</p> <p>** Division of Health Inspection report was found on 08/08/07 and is now posted on bulletin board in the dining room. **</p>	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 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 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.	A23		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 (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. (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 (2) Based on observation and interview the facility failed to have a copy of the last annual survey conducted by the Licensing Authority available at the facility for review when requested. The findings are: A. On 5/24/07 at 3:45 p.m. during tour of the facility, the last annual survey conducted by the Licensing Authority was not available for review. 1. A Department of Health Representative requested to see the last annual survey from	A23		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 Employee #2, and this employee stated, "I don't know where that is, or where she keeps it." Refer to 7.8.2.23 A (11) (13) Based on record review and interview the facility failed to have 4 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 5/24/07 at 5:10 p.m. review of the employee personnel files revealed the following: a. Employee #1 was hired on 11/20/03 and review of the annual in-services revealed that the last in-service this employee had was on 11/20/04. b. Employee #2 was hired on 9/17/06 and no documentation of an orientation or annual or on-going in-services was located in the personnel file. c. Employee #3 was hired on 5/16/03 and the only documentation of an orientation and annual or on-going in-services located in the file was dated 6/8/06. d. Employee #4 was hired on 2/1/01 and the only documentation of an orientation and annual or on-going in-services in the file was dated 6/8/06. B. On 5/24/07 at 5:30 p.m. during interview, Employee #2 stated, "when I was hired, I just got talked to, I don't ever remember going through an orientation or a check off list as to what was expected."	A23		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
--------------------------------------------------	-----------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 7

C. On 5/24/07 at 6:45 p.m. during interview, Employee #1 stated, "regarding the trainings, we haven't got one in quite a while. If we ever have had a abuse, neglect training, I sure don't remember

A23

A26 7 NMAC 8.2.26 RESIDENT ASSESSMENT

A26

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.
- (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.

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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	<p>Continued From page 8</p> <p>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 A</p> <p>Based on record review and interview, the facility failed to ensure that 6 of 6 sampled resident assessments (R#1-6) were being reviewed every six (6) months. The findings are:</p> <p>A. On 5/24/07 at 6:45 p.m. review of residents (#1-6) records revealed the following: 1. Residents #1,3,4,5's last individual assessments were completed on 10/28/06. No current assessments for 2007 were located in the resident's records. 2. Resident #2's last assessment was completed on 2/7/06. No current assessment for 2007 was in the resident's record. 3. Resident #6's last assessment was completed on 8/7/06. No current assessment for 2007 was in the resident's record.</p> <p>B. On 5/24/07 at 6:45 p.m. during interview, Employee #1 stated, "she [the owner of the facility] has a nurse that comes in to help her every so often, but I know those [referring to the resident assessments and ISP's (Individual Service Plans)] are overdue."</p>	A26	<p>A26 A.1 - Residents 1-3-4-5</p> <p>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</p> <p>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</p> <p>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</p> <p>Resident 5 - 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</p>	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 C. On 5/25/07 at 10:47 a.m. during interview, the owner of the facility stated, "yes, I do these [referring to the resident 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	A.2 - Resident 2 Resident 2 - 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	
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:	A27	A.3 - 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 B. This is an oversight on the part of Director but there is no excuse so Director will review the folders every 30 days to make sure the assessment is updated and on time. C. This was completed on 05/27/07	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 Surveyor: 20402 Refer to 7.8.2.27 A Based on record review and interview, the facility failed to have 6 of 6 sampled residents (R#1-6) Individual Service Plans reviewed every six months by a licensed nurse. The findings are: A. On 5/24/07 at 6:45 p.m. review of the residents (R#1-6) records revealed the following: 1. Residents (R#1,5) last ISP (Individual Service Plan) was completed on 10/28/06. No current ISP reviewed by a licensed nurse was located in the residents records. 2. Residents (R#2,4) last ISP was completed on 7/27/06. No current ISP reviewed by a licensed nurse was located in the residents records. 3. Resident (R#3) who was admitted on 6/8/06. No documentation of an ISP ever being completed, could be located in the residents record. 4. Resident (R#6) last ISP was completed on 8/7/06. No current ISP reviewed by a licensed nurse was located in the resident's records. B. On 5/24/07 at 6:45 p.m. during interview, Employee #1 stated, "she [the owner of the facility] has a nurse that comes in to help her every so often, but I know those [referring to the resident assessments and ISP's (Individual Service Plans)] are overdue." C. On 5/25/07 at 10:47 a.m. during interview, the owner of the facility stated, "yes, I do these [referring to the resident 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	A27 1. - Resident 1-5 Resident 1 - Service plan has been updated by Juliana Bonney on 05/27/07 and the registered nurse signed on it. A copy is in place in resident's folder. Emma Eriacho is registered nurse See attachment for copy Resident 5 - Service plan has been updated by Juliana Bonney on 05/27/07 and Emma Eriacho the registered nurse signed on it. A copy is in place in resident's folder. See attachment for copy 2. - Residents 2-4 Resident 2 - Service plan 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 for copy Resident 4 - Service plan has been updated by Juliana Bonney on 05/27/07 and the registered nurse, Emma Eriacho,	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
--------------------------------------------------	-----------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

A28

Continued From page 11
A28 7 NMAC 8.2.28 RESIDENT ACTIVITIES

A28

A28

7.8.2.28 RESIDENT ACTIVITIES: Each adult residential care facility shall provide or make available, and post, recreational and/or social activities. Each facility must encourage residents to participate in recreational and/or social activities to promote physical, mental, and Psycho social well-being.
[6-10-75, 7-11-86, 4-7-97; 7.8.2.8 NMAC - Rn, 7 NMAC.8.2.28, 8-31-00]
This REQUIREMENT is not met as evidenced by:
Surveyor: 20402
Refer to 7.8.2.28

Based on observation and interview, the facility failed to make available or encourage 6 of 6 sampled residents (R#1-6) to participate in recreational and/or social activities. The findings are:

A. On 5/23/07 at 5:00 p.m. during interview, an Ombudsman representative from the Aging and Long Term Services department stated that when she went out to the facility in January and February of this year, no activities were being provided to the residents.

B. On 5/24/07 at 4:15 p.m. observation of the facilities activity calender dated May 2007 indicated several activities (such as crafts, horse shoes, walking, and visits) that were to be going on at various times of the day. During the entire complaint investigation conducted on 5/24/07, no activities were observed as being offered or provided to any of the residents.

1. At 4:20 p.m. four residents were observed lying in bed sleeping, one resident was watching TV, and another resident was walking around. At

A. Activities have been calandered and posted on bullentin Board in the kitchen. Most of the time, each resident has been encouraged to participate in activities provided to them. We can only encourage them, we can not force them to participate. It is a violation of their rights. I do not know why the staff did not announce the activity. They are supposed to be doing it. Therefore the staff members have been told (on May 25, 2007) to encourage the reside ts to participate as much as they can in the activities provided for them. If the resident refuses to participate in activities there is nothing we can do about it. We can only encourage them to be involved.

B. A meeting was held on May 26, 2007 to inform the staff members to offer activities as much as possible for the residents. See attached for list.

C. This was completed 05/25/07

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
--------------------------------------------------	----------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

A28	Continued From page 12 this time, an activity "Horse shoes" was listed on the activity calender as the activity that was to be going on. C. On 5/24/07 at 4:20 p.m. during interview, resident (R#4) stated, "we don't do much here, just sit outside, or go for a walk."	A28	A36 A. The Director went through all medication for these residents 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.	
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	A36	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 touch any medication until she passes her test. She did not pass her test the first or second she took it. The Director is going to work with staff member step by step again to prepare her for the third test. Staff member has until the end of August 2007 to take and pass third test. Also in the meeting held on May 26, 2007 all staff members were told 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	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 shall not be used for another resident. 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	A36			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 symptoms persist. (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 A, B, C, D Based on observation, record review and interview, the facility failed to ensure the following: a) that Licensed health care professionals are responsible for the administration of medications to 6 of 6 sample residents (R#1-6), b) all staff assisting with medications have successfully completed a State approved assistance with medication training program c) that no medications be started, changed or discontinued by the facility without an order by the physician, and d) the Medication Administration Record (MAR) documentation was accurate. The findings are: A. On 5/24/07 at 3:30 p.m. during interview, Employee #2 stated at first, "I don't touch the meds, Employee #1 does." Employee #2 then stated, "she [employee #1] already fixes the meds for me and has ever since I started here last September. In the afternoon and evening, I give the meds." When a Department of Health Representative asked this employee "what meds	A36		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 do you give?" Employee #2 stated, "I give [resident #5 her meds for Parkinson and resident #2 his for Diabetes.] I give it to them before they eat. I put it in their hands and they take it with water." Employee #2 stated, "with the meds, I don't have a certificate, I took the test but failed and need to take it again. She [employee#1] has a certificate but I don't know where she keeps it. 1. Employee #2 further stated, "the meds for residents #2,3,5 are already prepared in the medication cups for me to give to the residents. With resident R#2, I give him his, at 5:00 p.m. and with resident R#5, I give her her meds at 12:00 p.m." B. On 5/24/07 at 4:00 p.m. observation of posted employee certificates to Assist residents with medications revealed there to be no Certificate to Assist with Medications for Employee #1 or Employee #2. Employee #1's Medication Assistance Certificate could only be located in the employee personnel file. C. On 5/24/07 at 4:45 p.m. observation of the medication file cabinet revealed two medication cups with prepared medication in them ready to give to residents. Employee #2 was asked by a state surveyor who and what those medications were for and the employee stated, "one for resident #5's parkinsons and the others I think are for resident #2's diabetes but I can't pronounce the names of them." 1. At 5:00 p.m. Employee #2 stated "Employee #1 signs on the MARS (Medication Administration Records) that she gives the meds. She gives the 8:00 am meds. I do the 12 noon, and 5:00 p.m. meds but I don't sign on the MARS. She [employee #1] does. I was told when I get my certificate, then I will start signing on the MARS, but until then she's been doing it."	A36		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 16 D. On 5/24/07 at 5:30 p.m. observation of Employee #2 revealed this employee walking to the medication file cabinet, taking out two small medication cups of prepared medications for resident #2 and #5. Employee #2 gave resident #2 his medications at the dining table by placing them in his hands and watching the resident take them. This employee also placed resident #5's medications in her hand and the resident took it with a glass of water. Employee #2 stated, "I don't need to sign on the MAR because she [employee #1] has already done that." 1. Review of the MAR for the Month of MAY 2007 revealed only the initials of Employee #1 as giving the residents their medications. Employee #2 did not initial on the MAR that she gave the residents their medications. E. On 5/24/07 at 5:45 p.m. during interview, Employee #1 stated, "when I come in at 6:00 p.m. I put the meds in the cups for in the morning. We have a lady [resident #5] who gets them at 12 p.m. and 4 p.m. I count those out, leave them in the cups for [employee #2] to give out the following day. She [employee #1] gives out meds at 12 noon and 4 p.m." Employee #1 then stated, "I come in on my days off and count out the meds. They can't touch the meds, they can pour them out. But I sign on the MAR. They [meaning other employees] can't until they have certificates." 1. When reviewing the May 2007 MAR with employee #1 regarding the medications that were given to residents #2 and 5, on the day shift, this employee stated, "I will sign on that tonight on the 12 noon, and 4:00 p.m. areas that they got their meds." F. On 5/24/07 at 6:30 p.m. when comparing	A36		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 17 residents medications to the MARS, the following discrepancies were noted for residents (R#1,2,5): 1. Resident #1's medication box contained a bottle of Ambien 5 mg tabs. The label on the medication read: take 1 tablet by mouth at bedtime. The expiration date on this bottle read 9/26/06. When it was compared to the MAR, this medication was not listed on the MAR nor was their a physicians order located in the residents record to discontinue or stop the medication. 2. Resident #2's medication box contained a bottle of Cyanocobalamin 1000 mcg tabs which read to take 2 tablets by mouth every day. When this was compared to the MAR, the hand written dosage on the MAR read: Cyanobalamin 600 mg take 2 tablets daily for B12. a. When Employee #1 was asked which dose the resident was to be getting, this employee stated, "I think I must have copied it off the order wrong." b. An additional medication located in resident #2's medication box was Terazosin HCL 5 mg cap. The label on the bottle read: Take 1 capsule at bedtime for Prostate and Blood Pressure. When this medication was compared to the MAR, it was not indicated anywhere on the MAR. 3. Resident #5's medication box contained a bottle of Nisoldipine 10 mg tab. The label on the medication read: Take 1 tab by mouth for High BP or Hypertension. When this medication was compared to the MAR, this medication was not listed on the MAR. Employee #1 stated, "I copied that from the old sheet." a. An additional medication located in the medication box was Lorazepam 1 mg tab. When compared to the MAR, the MAR listed the hand written dosage as Lorazepam 2 mg. The physicians order could not be located in the	A36		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 18 resident's chart and Employee #1 stated, "Oh she just gets 1 mg." G. 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 file cabinet, staff pre-pouring medications, meds not being labeled and are being pre-poured, poor record keeping and not accounting for all controlled substances, and being difficult for the consultant pharmacist to reconcile the MARS and physician orders, and additionally, employees signing on the MARS that the same person has given the meds when someone else is giving the medications.	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. 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	A38		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 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 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 Based on observation and interview the facility failed to ensure that all food in the facilities refrigerator and freezer 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:	A38		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 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, the first ten items she pulled out of the refrigerator were from 1997-2000. In the freezer, she stated, "the meat looked old." She stated that she went back out to the facility today (5/23/07) and "the potatoes were wrinkled and squishy." B. On 5/24/07 at 4:00 p.m. during observation of the facilities kitchen the following items were noted: 1 5.31 lb (2.41kg) bottle Classic Sysco container filled with mashed potatoes, squished bread, vegetables, celery, corn, and gravy sitting on the floor next to the trash can. this container had a strong odor of rotted food coming from it. 2 rotten, brown apples sitting in a box next to the microwave on the counter top. C. On 5/24/07 at 4:30 p.m. during observation of the facilities refrigerator, the following items were found: 1 5.2 oz box Garlic & Fine Herb Gournay Cheese. The label on the box says 06, Feb 07 on it. 1 11.5 fl. oz Marie's Honey Dijon Salad dressing dated Dec 17, 06 1 24 Fl. oz Zesty Italian dressing salad dressing. (No lid on the container, and the label reads 12 Aug 2005) 1 16 fl. oz bottle Just 2 Good Italian Dressing. The label says best if used by: April 24, 2006 1 12 fl. oz Marie's lite chunky blue cheese dressing. The label says Dec 30, 2006 1 12 fl. oz Marie's Creamy Italian Garlic dressing. The label reads Dec 16, 2006 1 12.9 oz bottle carb option BBQ sauce	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 front of the inspector. B. A meeting was held on May 25, 2007 with the staff members and instructed not to continue refilling the bottles and frozen bags 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 05/25/07	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 21 dated May 12, 2006 1 16 oz. Pace Picante Sauce. The date on the label reads May 3, 2006 1 piece of Bologna located in the bottom pull out drawer in a clear plastic baggy with no date or label on it. 1 rotted squishy green Bell Pepper 1 piece block cheese in a large clear plastic baggy that is labeled 10/1/06 1 Quart Mountain High Low Fat All Natural Yoghurt Plain. The label on the container reads: Best if used by 4/8/07 1/2 Hickory Farm Beef Sausage located in a large clear plastic baggy with no date or label. D. On 5/24/07 at 4:45 p.m. during observation of the facilities kitchen Freezer, the following items were found: a opened 1/2 pkg 48 oz. of Coronado Brand Weiners with Pork, Beef, and Chicken. There is no date or label on the Weiners and they have frost on them 1/2 carton of frozen Grapes with frost on the grapes 1 large opened bag of frozen potatoes with no label on it 1 large frozen clear baggy of chicken with no date or label on it 1 large frozen bag of bacon strips in a clear baggy that is labeled 8/10/06 1 large opened bag of ham strips. The label on the bag reads to use by 12/12/04 1 large bag of ham strips with no date or label on the bag 1 opened large bag with 4 frozen chicken patties with no date or label on the bag E. On 5/24/07 at 4:50 p.m. during observation of the facilities additional freezer located in the	A38			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5533	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/24/2007
NAME OF PROVIDER OR SUPPLIER BONNEY FAMILY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 802 EAST HILL 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 22 Laundry, the following items were found: 1 pkg of frozen chicken legs in a clear baggy that is tied with a rubber band. There is no date or label on the baggy. 2 pot pies in a clear baggy that is labeled 10/18/06 1 pkg. Frozen Ham/Pepperoni slices that is dated 9/29/06 1 small frozen package of Hamburger meat dated 8/23/06 F. On 5/24/07 at 5:00 p.m. during interview, Employee #2 stated that she was unaware that the food was outdated and needed labels.	A38			