

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5796	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/13/2017
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NAME OF PROVIDER OR SUPPLIER KINGSTON RESIDENCE OF SANTA FE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 LEGACY COURT SANTA FE, NM 87507
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	<p>Initial Comments</p> <p>A complaint investigation was conducted (NM00029862) on 11/18/15. All items in the complaint have been substantiated. This led to a complete Life Safety Code Survey being conducted on the same day.</p> <p>The reported census during the survey was 117 residents.</p> <p>Deficiencies were cited as a result of a complete survey conducted on November 18, 2015, for the Life Safety Code portion of the New Mexico Regulations Governing Requirements for Adult Residential Care Facilities 7.8.2 NMAC.</p> <p>A revisit onsite survey was conducted on 10/03/2016.</p> <p>Deficiencies were recited as a result of the revisit survey conducted on 10/03/2016.</p>	{A 000}		

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE