

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5796</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/14/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KINGSTON RESIDENCE OF SANTA FE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2400 LEGACY COURT</b> <b>SANTA FE, NM 87507</b>
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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 survey for intakes NM#30003 and NM#30004 was completed on 07/14/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.</p> <p>The complaints were unsubstantiated with no deficiencies cited.</p>	A 000		

Division of Health Improvement LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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