

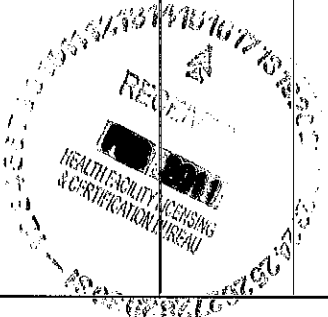
Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2011
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NAME OF PROVIDER OR SUPPLIER PONCE DE LEON	STREET ADDRESS, CITY, STATE, ZIP CODE 640 ALTA VISTA SANTA FE, NM 87505
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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
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A 000	<p>Initial Comments</p> <p>A Complaint Investigation was completed for intake #NM00027849 for NMAC 7.8.2 regulations governing Assisted Living facilities.</p> <p>The Complaint was Unsubstantiated for allegation of Abuse. No deficient practices were cited as a result of this investigation.</p>	A 000	<p><i>Scanned 2-18-11 EP</i></p>	
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Division of Health Improvement <i>[Signature]</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>EXECUTIVE DIRECTOR</i>	(X6) DATE <i>2/14/11</i>
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