

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>05/03/2010</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 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 01	<p><b>OPENING REMARKS</b></p> <p>5/3/2010</p> <p>A complaint survey was conducted for Intake NM00027555.</p> <p>The complaint was not substantiated and no deficiencies were cited.</p>	A 01		

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