

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/21/2020
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NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410
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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>Offsite surveillance review were conducted on 07/21/20 related to COVID-19 infection prevention and control. No deficiencies cited.</p> <p>Offsite complaint investigation completed, Complaint Intake #47314 was unsubstantiated with no deficiencies were cited.</p>	A 000		

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