

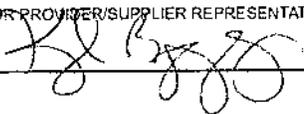
Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5884	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/25/2019
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NAME OF PROVIDER OR SUPPLIER SUNDANCE CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 209 WEST ADAMS AVENUE GALLUP, NM 87301
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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>No deficiencies were cited for a complaint survey completed on 09/25/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.</p> <p>Complaint intake [REDACTED] was unsubstantiated with no deficiencies cited.</p>	A 000		

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



TITLE

ADMINISTRATOR

(X6) DATE

10/8/19