

Division of Health Improvement

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>5873</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>03/18/2020</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ARISTOCRAT OF ALAMOGORDO II (THE)</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>252 ROBERT H BRADLEY DRIVE<br/>ALAMOGORDO, NM 88310</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>An Onsite Surveillance survey was conducted on 03/16/20, related to Covid 19 infection prevention and control. No deficiencies cited.</p> | A 000         |   |                    |

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