

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5884</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/08/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUNDANCE CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>209 WEST ADAMS AVENUE GALLUP, NM 87301</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 00	<p><b>NO DEFICIENCIES</b></p> <p>This Facility is in Compliance with all New Mexico Regulations Governing Adult Residential Care Facilities 7 NMAC 8.2.</p> <p>A complaint survey was conducted with no deficiencies cited for Complaint Intake # NM00027495 on 04/08/10.</p>	A 00		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_