Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING _____ B. WING _____	10/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING	1001 YORK DRIVE CLOVIS, NM 88101

(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	NO DEFICIENCIES This Facility is in Compliance with all New Mexico Regulations Governing Adult Residential Care Facilities 7 NMAC 8.2. No deficiencies were cited on October 8,2009 for New Mexico Regulations Governing Adult Residential Care Facilities, NMAC 7.8.2.	A 00		

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RECEIVED NOV 20 HEALTH FACILITY & CERTIFICATION

Division of Health Improvement

Maynie C Ray6 — Director, Owner — TITLE — 11/6/09 — (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE