

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 10/28/2010
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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
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A 000 Initial Comments

A 000

A Complaint investigation was completed for intake #NM0007559 for NMAC 7.8.2 regulations governing Assisted Living facilities. The Complaint was Unsubstantiated for allegation of Neglect.

*Scanned
11-10-10
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Division of Health Improvement

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

TITLE
Executive Director

(X6) DATE
11/4/10

STATE FORM

6899

RMC711

If continuation sheet 1 of 1

ORIGINAL