

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5873	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/17/2014
NAME OF PROVIDER OR SUPPLIER ARISTOCRAT OF ALAMOGORDO II (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 252 ROBERT BRADLEY DRIVE ALAMOGORDO, NM 88310		
(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	Initial Comments Incident investigations were completed for intakes NM00029190 and NM00029404 on 08/17/14 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The incidents were unsubstantiated with no deficiencies cited.	A 000	<div style="border: 1px solid black; padding: 5px; text-align: center;"> <p>RECEIVED</p> <p>SEP 25 2014</p> <p>HEALTH FACILITY LICENSING & CERTIFICATION BUREAU</p> </div>	

Beverly Gunnars 10/18/2014 scan 10/18/14

Division of Health Improvement

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

TITLE

(X6) DATE

Beverly Gunnars

Administrator