

Division of Health Improvement

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5746 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 02/01/2015 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER CRANE'S ROOST CARE HOME, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH PARK AVENUE AZTEC, NM 87410 |
|---|---|

| (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>No deficiencies were cited during a complaint survey completed on 02/01/15 for the New Mexico requirements for Assisted Living for Adults, 7.8.2 NMAC. Complaint NM #29611 was unsubstantiated.</p> | A 000 | | |

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