

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5119	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/23/2020
NAME OF PROVIDER OR SUPPLIER VILLA GUADALUPE/LITTLE SISTERS OF THE POOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 MARK AVENUE GALLUP, NM 87301		
(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 An Offsite Surveillance survey was conducted on 04/03/20 related to CoVID-19 infection prevention and control. No deficiencies were cited. No deficiencies were cited during a offsite Complaint survey completed on 04/23/20 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake #NM44252 was unsubstantiated with no deficiencies cited. An onsite surveillance survey was conducted on 05/14/20 related to COVID 19 infection prevention and control. No deficiencies were cited.	A 000		

Division of Health Improvement

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

TITLE

(X6) DATE