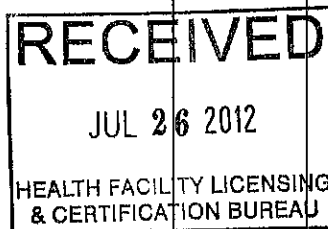


Division of Health Improvement

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 03/27/2012
NAME OF PROVIDER OR SUPPLIER VILLA GUADALUPE/LITTLE SISTERS OF THE			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 A Complaint investigation was completed for intake #NM00028042 for NMAC 7.8.2 regulations governing Assisted Living facilities. The Complaint was Substantiated.	A 000 <i>Scanned 07-27-12 J.O.</i>			



Division of Health Improvement

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

Sister Bernadette Castle

TITLE *Adm*

(X6) DATE

7/23/12

STATE FORM

6899

4LY511

If continuation sheet 1 of 1