Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5119	A. BUILDING _____ B. WING _____	C 03/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA GUADALUPE/LITTLE SISTERS OF THE	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	Scanned 07-27-12 J.O.	

RECEIVED
JUL 26 2012
HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Division of Health Improvement

Sister Dorothy Castle — TITLE Adm — (X6) DATE 7/23/12

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