Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5729	A. BUILDING _____ B. WING _____	C 09/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT ASSISTED LIVING (THE)	252 ROBERT H BRADLEY 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 00	NO DEFICIENCIES This Facility is in Compliance with all New Mexico Regulations Governing Adult Residential Care Facilities 7 NMAC 8.2. Surveyor: 22739 A complaint investigation was initiated 09/12/08 and the facility was found to be in substantial compliance with Requirements for Adult Residential Care Facilities, 7.8.2 NMAC and no deficiencies were cited.	A 00		

Scanned 11-5-08 JM

Division of Health Improvement

Jeanne Morales — TITLE: Exec. Director — (X6) DATE: 10/9/08

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

STATE FORM 6899 O24311 If continuation sheet 1 of 1