

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 10/27/2014
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA GUADALUPE/LITTLE SISTERS OF THE I 1900 MARK AVENUE
GALLUP, NM 87301

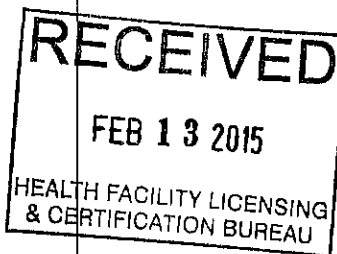
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Initial Comments

No deficiencies were cited during a complaint survey completed on 10/27/14 for the New Mexico requirements for Assisted Living for Adults, 7.8.2 NMAC. Complaint NM # 29270 was unsubstantiated. The survey was conducted via telephone interview and document review. There was no on-site visit.

A 000



2/17/2015 Amy Scanned

St Mary William Leedka Adm.

4/7/15

Division of Health Improvement

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

TITLE

(X6) DATE