

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5884	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2007	
NAME OF PROVIDER OR SUPPLIER SUNDANCE CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 209 WEST ADAMS 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 00	<p>NO DEFICIENCIES</p> <p>This Facility is in Compliance with all New Mexico Regulations Governing Adult Residential Care Facilities 7 NMAC 8.2. No Deficiencies found on initial survey of 8/27/07.</p>	A 00	<p style="text-align: center;"><i>Scanned 9-6-07 JL</i></p>	

Division of Health Improvement

Mary Johnston

Director

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

(X6) DATE
9/4/07

STATE FORM

SEP 5 2007 6111

If continuation sheet 1 of 1