

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>1ST Original</i>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5563	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2008
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUNSET VISTA	STREET ADDRESS, CITY, STATE, ZIP CODE 3650 NORTH FOWLER SILVER CITY, NM 88061
---	---

(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. Surveyor: 22697</p> <p>No deficiencies</p>	A 00	<p><i>Scanned 10/14/08 JW</i></p>	

Division of Health Improvement

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

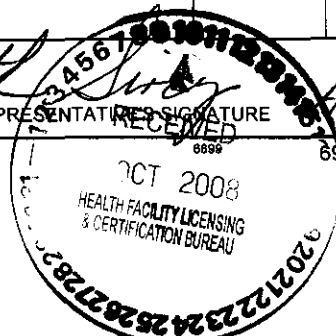
STATE FORM

Elizabeth S. ...
ADMINISTRATOR

TITLE

(X6) DATE

10-6-08



69ZR11