

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5503	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2023
NAME OF PROVIDER OR SUPPLIER SUNSET VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 3650 NORTH FOWLER AVE 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 000	<p>Initial Comments</p> <p>No deficiencies were cited during a Full-Onsite/Complaint survey completed on [REDACTED] 23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults.</p> <p>Census: 22</p> <p>Complaint Intake [REDACTED] was investigated with no deficiencies cited.</p> <p>Complaint Intake [REDACTED] was investigated with no deficiencies cited.</p>	A 000		

Division of Health Improvement

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

STATE FORM

E. Elizabeth Lively

TITLE

ADMINISTRATOR

(X8) DATE

12-17-23

V6HK11