

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5647</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>01/24/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAREFREE LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111</b>
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(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 Revisit/Follow-up survey completed on 01/24/20 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.</p>	{A 000}		

Division of Health Improvement LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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