

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>2260</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/30/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BUENA VISTA SENIOR CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8505 RANCHO SANTA FE PLACE NE ALBUQUERQUE, NM 87113</b>
--	---

(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>An offsite suviallance survey was conducted related to COVID` 19 infection prevention and control on 03/30/20.. No deficiencies were found..</p>	A 000		

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