

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>2139</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>09/02/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LITTLE ROSES HOME CARE OF THE SOUTH WEST</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4917 REGINA CIRCLE NW</b> <b>ALBUQUERQUE, NM 87105</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>The facility was found in compliance during a Revisit-Follow-up survey event # V59M12 completed on 09/02/20, for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.</p>	{A 000}		

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