

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>2125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CASA BELLA RESIDENTIAL CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2919 SPITZ ST LAS CRUCES, NM 88005</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>An offsite surveillance survey was conducted on 04/21/20 related to Covid-19 infection, prevention and control. No deficiencies cited.</p>	A 000		

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