

Division of Health Improvement

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|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>2039</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/19/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SIERRA SPRINGS ASSISTED LIVING</b> |                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>503 LOS LENTES ROAD NE<br/>LOS LUNAS, NM 87031</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                        | ID<br>PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                                     | Initial Comments<br><br>An Onsite Surveillance survey was conducted on<br>03/19/20, related to Covid 19 infection prevention<br>and control. No deficiencies cited. | A 000                                                                                          |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE