

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/31/2017
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NAME OF PROVIDER OR SUPPLIER SIERRA SPRINGS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 503 LOS LENTES ROAD NE LOS LUNAS, NM 87031
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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 as a result of a Revisit/Follow-up survey conducted on 08/31/17, for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The facility was found to be in substantial compliance.</p>	{A 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____