Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: **01 - ALL-CARE ASSISTED LIVING** B. WING _____	**03/24/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	**1001 YORK DRIVE** **CLOVIS, NM 88101**

(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	Initial Comments On March 24, 2015, a Life Safety Code survey was conducted for the remodeled area, in response to a complaint [NM00029635]. Occupancy of the remodeled area prior to a Life Safety Code survey. The complaint was substantiated with no deficiecencies issued. At this time, the remodel did not match the approved plans (Client bedroom 5 door not located as shown on approved plan).The change does not affect the safety of the client. Therefore, the facility was found in compliance with the Life Safety Code portion of the New Mexico State regulations governing Requirements for Adult Residential Care Facilities, 7.8.2 NMAC.	A 000		

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