Division of Health Improvement

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2049 | | 04/23/2020 |

NAME OF PROVIDER OR SUPPLIER

**MILLIE'S ASSISTED LIVING COMMUNITY, LLC**

STREET ADDRESS, CITY, STATE, ZIP CODE

**600 NORTH HUDSON STREET**
**SILVER CITY, NM 88061**

| (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<br><br>Offsite Surveillence survey was conducted on 04/23/2020, related to COVID 19 infection controil prevention and control. No def cited. | A 000 | | |

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