

Division of Health Improvement

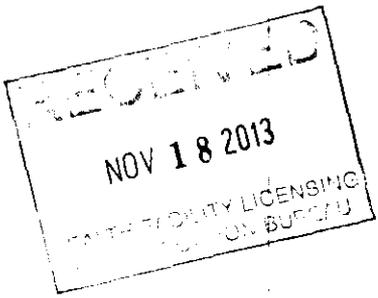
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/17/2013
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NAME OF PROVIDER OR SUPPLIER SIERRA SPRINGS 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
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A 000	Initial Comments A complaint investigation was completed on 10/17/13 for intake NM 00029064 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was unsubstantiated with no deficiencies cited.	A 000		
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Scanned
KH 11/20/13



Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Frances Johnson

TITLE

Administrator

(X6) DATE