

Division of Health Improvement

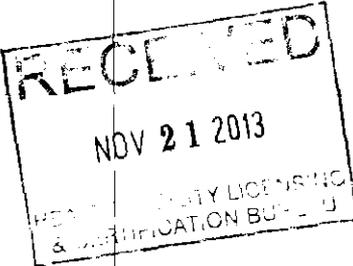
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5712</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/22/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SENIOR LIVING SYSTEMS THOMAS RD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>05 THOMAS ROAD LOS LUNAS, NM 87031</b>
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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 10/22/13 for intake NM #28881 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 11/22/13 KH



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



TITLE  
*D. A. Cam*

(X6) DATE  
*11/11/13*