

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>1st Original</i>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/15/2012
NAME OF PROVIDER OR SUPPLIER SIERRA SPRINGS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 503 LOS LENTES ROAD NE LOS LUNAS, NM 87031		
(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 A complaint investigation was completed for intake NM00028020 on 03/15/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was unsubstantiated with no deficiencies cited.	A 000 <i>Scanned 04-26-12 J.D.</i>		

Division of Health Improvement

Frances Johnson

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

4/11/12