

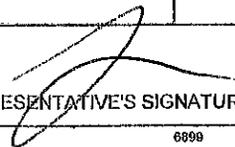
Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  5712	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/19/2012
NAME OF PROVIDER OR SUPPLIER  SENIOR LIVING SYSTEMS THOMAS RD			STREET ADDRESS, CITY, STATE, ZIP CODE 05 THOMAS ROAD 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 NM00028294 on 03/19/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.  The Complaint was Substantiated with no deficiencies cited.	A 000 <i>Scanned 05-03-12 J.P.</i>			

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Division of Health Improvement

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



TITLE *President*

(X6) DATE

*4/24/2012*