

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 R-C 02/23/2017
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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
{A 000}	<p>Initial Comments</p> <p>A Revisit/Follow-up survey was completed on 02/23/17 for survey dated 10/05/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.</p> <p>No deficiencies were cited.</p>	{A 000}		

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