Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4028	A. BUILDING: **01** B. WING _____	**09/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR OF ALBUQUERQUE	**8051 PALOMAS AVE NE** **ALBUQUERQUE, NM 87109**

(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 On September 27, 2017, an initial Life Safety Code survey was conducted at the above referenced facility, as per provider's request. During the survey the following items were identified. 1. Emergency Shut Off Switch on emergency generator, shall be relocated to the exterior of the housing, remotely located adjacent to the generator. 2. Remote annunciator for emergency generator, shall be installed at a constantly attended station within the facility. On October 11, 2017, correspondence was sent to this office via email, addressing all deficiencies. At this time the facility is found in substantial compliance with the Life Safety Code Portion of the New Mexico State Requirements for Assisted Living Facilities NMAC 7.8.2	A 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE