

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY DAY ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 205 DAY STREET GALLUP, NM 87301		
(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 14, 2016 an initial Life Safety Code survey was conducted at the above referenced facility per the provider's request. The facility is found to be in substantial compliance with the Life Safety Code portion of the New Mexico State Regulations for Assisted Living Facilities for Adults, 7 NMAC 8.2. Temporary licensure is recommended.	A 000		

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

TITLE

(X6) DATE