Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7092	A. BUILDING: _____ B. WING _____	C 01/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN BLESSINGS ASSISTED LIVING	400 SUNSET BLVD LOGAN, NM 88426

(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
8 000	Initial Comments Deficiencies were not cited during a Complaint survey completed on 01/18/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living Facilities for Adults. Resident Census: [redacted] Complaint Intake NM [redacted] was investigated and deficiencies were not cited. Complaint Intake NM [redacted] was investigated and deficiencies were not cited.	8 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X5) DATE: 2/3/25