

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER GOOD LIFE SENIOR LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CHERRY LANE CARLSBAD, NM 88220		
(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 October 6, 2015 and initial Life Safety Code Survey was conducted at the above referenced facility, as per the provider's request. At this time, temporary licensure was not recommended. On October 7, 2015 correspondence and photos were received by this office via email from the facility addressing the installation of signage to indicate location of FDC (Fire Department Connection), and adjustment of exit door binding in frame. At this time the facility is found in substantial compliance with the Life Safety Code Portion of the New Mexico State Regulations governing requirements for Assisted Living Facilities 7 NMAC 8.2 Temporary licensure of the space is recommended.	A 000		

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

TITLE

(X6) DATE