

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/27/2017
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 A Revisit/Follow up survey for survey dated 02/01/17 was completed on 04/27/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. No Deficiencies were cited as result of the survey.	{A 000}			

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

TITLE

(X6) DATE