

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 18, 2013, an initial Life Safety Code survey was completed for the facility per the provider's request. At that time, licensure was not recommended. On November 18, 2013, correspondence was received addressing all the concerns identified on 10/18/13. This facility was found to be in substantial compliance with the Life Safety Code portion of the New Mexico State Requirements for Assisted Living Facilities for Adults 7 NMAC 8.2 Therefore, I recommend licensure for a capacity of sixteen (16) residents.	A 000		

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

TITLE

(X6) DATE