

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2139	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2013
NAME OF PROVIDER OR SUPPLIER LITTLE ROSES HOME CARE OF THE SOUTH WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 4917 REGINA CIRCLE NW ALBUQUERQUE, NM 87105		
(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 August 15, 2013, an initial Life Safety Code survey was conducted per the provider's request. This is for a change of capacity from eight (8) to ten (10) residents. The facility was found to be in substantial compliance with the Life Safety Code portion of the New Mexico State Regulations for Assisted Living Facilities for Adults 7.8.2 NMAC	A 000		

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

TITLE

(X6) DATE