Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2139	A. BUILDING: **01** B. WING _____	**08/23/2012**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE ROSES HOME CARE OF THE SOUTH WEST	**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 01	OPENING REMARKS On August 23, 2012, a Life Safety Code survey was conducted for an increase of capacity at the above referenced facility per the provider ' s request. This facility was found 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. We recommend an increase of capacity for 8 residents with the following condition: 1. The two bedrooms and bathroom located on the second floor are not included in this approval and shall not be occupied by residents at this time. If these rooms are ever intended for resident use, the provider shall request review and approval of their building plans by this agency. No further action is required at this time.	A 01		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE