Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2246	A. BUILDING: **01** B. WING _____	**03/24/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA POSADA ASSISTED LIVING	**299 E MONTANA AVE** **LAS CRUCES, NM 88005**

(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 March 24, 2014, a Life Safety Code survey was conducted at the above referenced facility, by the provider's request. At this time, the facility was found to be in substantial compliance with the Life Safety Code and Rules and Regulations governing Requirements for Adult Residential Care Facilities NMAC 7.8.2. Therefore, I recommend ocupancy of the Assisted Living UNit (100 Wing). This facility is of Type V Protectioed construction and is fully sprinklered.	A 000		

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