STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2126	A. BUILDING _____ B. WING _____	01/16/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A NEW DAY ASSISTED LIVING	11212 MIRAVISTA PLACE SE ALBUQUERQUE, NM 87123

(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 00	NO DEFICIENCIES This Facility is in Compliance with all New Mexico Regulations Governing Adult Residential Care Facilities 7 NMAC 8.2.	A 00		

ES Acennal 01-30-08

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: R Enrique Vasquez

TITLE: OWNER

(X6) DATE: 01-23-'08

STATE FORM 6899 OTM011 If continuation sheet 1 of 1

JAN 28 2008