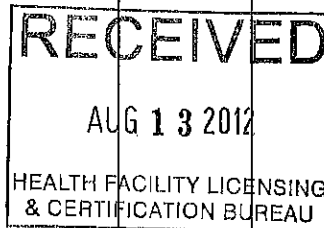


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2200	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/17/2012
NAME OF PROVIDER OR SUPPLIER CIELOS ABIERTOS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 TOREADOR NE ALBUQUERQUE, NM 87111		
(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 An Initial survey was completed for NMAC 7.8.2 regulations governing Assisted Living facilities. No deficiencies were cited.	A 000 <i>Scanned 08-15-12 S.B.</i>			



Division of Health Improvement

Carlos M. Figueroa
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE *Administrator* (X6) DATE *8/2/12*

STATE FORM

6899

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If continuation sheet 1 of 1

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