Division of Health Improvement

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2200 | A. BUILDING _____ B. WING _____ | 04/17/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CIELOS ABIERTOS ASSISTED LIVING | 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<br><br>An Initial survey was completed for NMAC 7.8.2 regulations governing Assisted Living facilities.<br><br>No deficiencies were cited. | A 000 | | |

Scanned 08-15-12 S.B.

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AUG 13 2012
HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Division of Health Improvement

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

TITLE Administrator (X6) DATE 8/7/12



ORIGINAL