

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/24/2023
NAME OF PROVIDER OR SUPPLIER ADVANTAGE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1729 WELLSRING AVE SE RIO RANCHO, NM 87124		
(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 No deficiencies were cited during a Complaint survey completed on 08/24/23 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living Facilities for Adults. Census 25 Complaint Intake #66895 was investigated with no deficiencies cited. A referral was made to the Employee Abuse Registry (EAR)	A 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

SOOP11

If continuation sheet 1 of 1

Jaymie Rickard *Executive Director*

10/25/23