

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/05/2012
NAME OF PROVIDER OR SUPPLIER GOOD LIFE SENIOR LIVING AND MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031		
(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 Complaint Investigations were completed for intake #'s NM00028379, NM00028397, NM00028402 for NMAC 7.8.2 regulations governing Assisted Living facilities. The Complaints were Unsubstantiated. Deficiencies were cited.	{A 000}			

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

TITLE

(X6) DATE