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: **01** B. WING _____	**02/22/2012**

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 On February 22, 2012, an initial Life Safety Code survey was conducted at the above referenced facility per the provider ' s request. The capacity requested is seven (7) residents. However, the plan review approval was for five (5) residents until the concerns regarding the fireplace in semi-private resident bedroom #106 were addressed. During this survey, it was verified that all concerns regarding semi-private resident bedroom #106 have been addressed. The facility was found in substantial compliance with the Life Safety Code portion of the New Mexico State Regulations for Adult Residential Care Facilities 7.8.2 NMAC. I recommend temporary licensure.	A 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE