

Division of Health Improvement

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>2217                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY<br>COMPLETED<br><br>07/27/2020  |
|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>HACIENDAS AT GRACE VILLAGE, LLC - UNIT A |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2802 CORTE DIOS<br>LAS CRUCES, NM 88011 |   |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                   |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |
| A 000  | Initial Comments<br><br>An Offsite Surveillance survey was conducted on 07/24/20, related to Covid 19 infection prevention and control. No deficiencies cited. |  | A 000   |  |

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

TITLE

(X6) DATE