

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>4049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BLUE HORIZON BOUTIQUE ASSISTED LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2707 SPITZ STREET BUILDING B LAS CRUCES, NM 88005</b>		
(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	<p>Initial Comments</p> <p>On August 14, 2018, an initial life safety code survey was conducted at the above referenced facility as per providers request.</p> <p>At this time the facility is found in substantial compliance with the Life Safety code Portion of the New Mexico State Regulations for Assisted Living Facilities 7.8.2 NMAC and the Life Safety Code 101, 2012 Edition.</p> <p>Temporary licensure is recommended.</p>	A 000		

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

TITLE

(X6) DATE