

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/10/2018
--	---	---	---

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	<p>Initial Comments</p> <p>On October 10, 2018, an initial Life Safety Code Survey was conducted at the above referenced facility, as per the provider's request.</p> <p>The facility is found to be in substantial compliance with the Life Safety Code portion of the New Mexico State Regulations for Assisted Living Facilities for Adults 7.8.2 NMAC. No Deficiencies were cited.</p> <p>Temporary licensure of this facility is recommended.</p>	A 000		

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____