

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/22/2015
NAME OF PROVIDER OR SUPPLIER CIELOS ABIERTOS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 All deficiencies were cleared during a revisit survey (for Event ID H5PH12) completed on 12/22/15 for the State of New Mexico Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC. The facility is in compliance with state regulations.	{A 000}			

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

TITLE

(X6) DATE