

Division of Health Improvement

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                 |                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>2218</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>02</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HACIENDAS AT GRACE VILLAGE, LLC - UNIT B</b> |                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2802 CORTE DIOS<br/>LAS CRUCES, NM 88011</b> |                                                                                                                          |                                                        |
| (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) | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                                               | <p>Initial Comments</p> <p>On February 11, 2013, an initial Life Safety Code survey was conducted at the facility per the provider's request.</p> <p>This facility was found to be in substantial compliance with the Life Safety Code portion of the New Mexico State Requirements for Assisted Living Facilities for Adults 7 NMAC 8.2</p> <p>I recommend temporary licensure.</p> | A 000                                                                                    |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE