

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/26/2016
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
(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 On May 26, 2016, an initial life safety code survey was conducted at the above referenced facility, as per the providers request. At this time, temporary licensure was not recommended. On May 31, 2016, photos were emailed to this office addressing ADA access on the exterior of the facility. 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 for Adults 7 NMAC 8.2 Temporary licensure of the facility is recommended.	A 000		

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

TITLE

(X6) DATE