Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5762	A. BUILDING: _____ B. WING _____	C 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE OF FARMINGTON (THE)	**1091 WEST MURRAY DRIVE FARMINGTON, NM 87401**

(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 A complaint investigation was completed for intake NM00028150 on 08/31/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was Unsubstantiated. No deficiencies were cited. A complaint investigation was completed for intake NM00028655 on 08/31/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was Unsubstantiated. No deficiencies were cited. A complaint investigation was completed for intake NM00028658 on 08/31/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was Unsubstantiated. No deficiencies were cited.	A 000		

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