

Division of Health Improvement

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2055 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/27/2020 |
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| NAME OF PROVIDER OR SUPPLIER BROOKDALE VALENCIA | STREET ADDRESS, CITY, STATE, ZIP CODE 300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108 |
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| (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 |
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| A 000 | <p>Initial Comments</p> <p>An Offsite Surveillance survey was conducted on 05/27/20, related to Covid 19 infection prevention and control. No deficiencies cited.</p> | A 000 | | |

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