

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>2258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/30/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODMARK AT UPTOWN (THE)</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7201 PROSPECT PLACE NE</b> <b>ALBUQUERQUE, NM 87110</b>
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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
A 000	<p>Initial Comments</p> <p>A Complaint survey was conducted for intake NM 00039086 on 10/30/19 for the state requirements of 7 NMAC 8.2 Regulations for Assisted Living.</p> <p>Complaint # NM 00039086 was unsubstantiated with no deficits cited.</p>	A 000		

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