

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5882</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/16/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAMINO RETIREMENT APARTMENTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>12101 LOMAS NE</b> <b>ALBUQUERQUE, NM 87112</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>Investigations were completed for intake NM00028540 and intake NM00028334 on 08/14/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The complaints were unsubstantiated with no deficiencies cited.</p>	A 000		

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