

Division of Health Improvement

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 C 01/18/2013
NAME OF PROVIDER OR SUPPLIER BROOKDALE PLACE AT VALENCIA		STREET ADDRESS, CITY, STATE, ZIP CODE 300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108		
(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>An investigation was completed for intake NM00028570 on 01/18/13 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.</p> <p>The Complaint was Unsubstantiated. No deficiencies were cited.</p> <p>An investigation was completed for intake NM00028891 on 01/18/13 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.</p> <p>The Complaint was Unsubstantiated. No deficiencies were cited.</p> <p>An investigation was completed for intake NM00028910 on 01/18/13 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.</p> <p>The Complaint was Unsubstantiated. No deficiencies were cited.</p> <p>An investigation was completed for intake NM00028918 on 01/18/13 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.</p> <p>The Complaint was Unsubstantiated. No deficiencies were cited.</p>	A 000		

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& CERTIFICATION BUREAU

Division of Health Improvement

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

Jane Wathenfeld

TITLE *Executive Director*

(X8) DATE

1/29/13