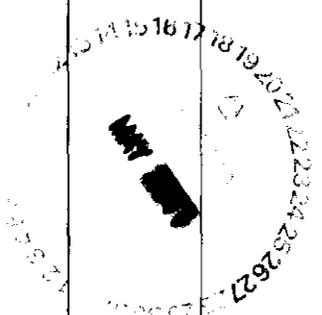


Division of Health Improvement

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>12/07/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAMINO RETIREMENT APARTMENTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>12101 LOMAS NE ALBUQUERQUE, NM 87112</b>		
(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 NM00027787. The Complaint was unsubstantiated with no deficiencies cited.	A 000		

*ef scanned 05-23-11*



Division of Health Improvement

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

*Charles P. [Signature]* ED

TITLE

(X6) DATE

5-17-2011