

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  5762	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/30/2012	
NAME OF PROVIDER OR SUPPLIER  BRIDGE OF FARMINGTON (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 1091 WEST MURRAY DRIVE FARMINGTON, NM 87401		
(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 investigation was completed for intake NM00028150 on 08/31/12 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>A complaint investigation was completed for intake NM00028655 on 08/31/12 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>A complaint investigation was completed for intake NM00028658 on 08/31/12 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>A 000</p> <p><i>Scanned 10-01-12 J.D.</i></p>		

**RECEIVED**

SEP 25 2012

HEALTH FACILITY LICENSING  
& CERTIFICATION BUREAU

Division of Health Improvement

*Leslie A. Reely*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*General manager* TITLE  
9-18-12 (X6) DATE

**ORIGINAL**