

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>R-C</b> <b>02/06/2017</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><b>Initial Comments</b></p> <p>A complaint investigation for intake NM00030019 and an On-site/Monitoring survey were completed on 08/04/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.</p> <p>Deficiencies were cited as result of the On-site/Monitoring survey.</p> <p>The Complaint was substantiated with deficiencies cited.</p> <p>A revisit/follow up survey was completed on 02/06/17 for previous survey dated 08/04/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.</p> <p>No deficiencies were cited.</p>	{A 000}		

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