

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5827</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/02/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TOUCHED BY A WHITE DOVE ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1605 CARDENAS DRIVE NE</b> <b>ALBUQUERQUE, NM 87110</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>No deficiencies were cited during an offsite revisit on 07/02/20 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.</p> <p>The facility was found to be in compliance.</p>	{A 000}		

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