

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 08/07/2019
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NAME OF PROVIDER OR SUPPLIER BROOKDALE TRAMWAY RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4910 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111
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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 a complaint survey completed on 08/07/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.</p> <p>Complaint Intake NM#38649 was unsubstantiated. No deficiencies cited.</p>	A 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____