

Division of Health Improvement

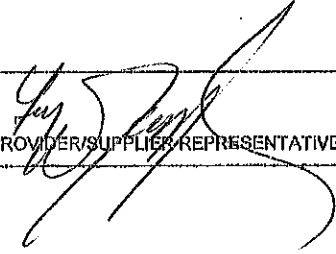
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5605	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2012
NAME OF PROVIDER OR SUPPLIER HIGHPOINTE CARE, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6001 ROGERS DRIVE NE ALBUQUERQUE, NM 87110		
(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)	(X6) COMPLETE DATE
A 000	Initial Comments A Complaint investigation was completed for Intake #NM00028509 for NMAC 7.8.2 regulations governing Assisted Living facilities. The Complaint was Substantiated with no deficiencies.	A 000 <i>Scanned 08-20-12 J.W.</i>		
	A Complaint investigation was completed for Intake #NM00028557 for NMAC 7.8.2 regulations governing Assisted Living facilities. The Complaint was Substantiated with no deficiencies.			

RECEIVED
 AUG 17 2012
 HEALTH FACILITY LICENSING
 & CERTIFICATION BUREAU

Division of Health Improvement

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

STATE FORM



TITLE

Director

(X8) DATE

7-30-2012

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CROV11

If continuation sheet 1 of 1