PRINTED: 03/08/2011
FORM APPROVED

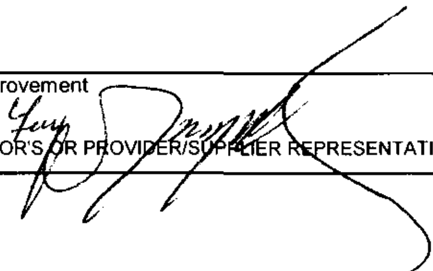
Division of Health Improvement

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 5605 | A. BUILDING ______<br>B. WING ______ | C<br>03/03/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HIGHPOINTE CARE, INC | 6001 ROGERS DRIVE NE<br>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) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 000 | Initial Comments<br><br>A Complaint Investigation was completed for intake #NM00027931 for NMAC 7.8.2 regulations governing Assisted Living facilities.<br><br>The Complaint was Unsubstantiated for allegation of Abuse. No deficient practices were cited as a result of this investigation. | A 000 | ED 03-18-11 Scanned | |

Division of Health Improvement



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

TITLE Director

(X6) DATE 3-16-2011

STATE FORM 6899 EF9M11 If continuation sheet 1 of 1

ORIGINAL