

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5831	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/22/2009
NAME OF PROVIDER OR SUPPLIER WESTWIND HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 6600 LOS VOLCANES NW ALBUQUERQUE, NM 87121	
(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)
A 00	<p>NO DEFICIENCIES</p> <p>This Facility is in Compliance with all New Mexico Regulations Governing Adult Residential Care Facilities 7 NMAC 8.2. Surveyor: 20402 No deficiencies were cited during a complaint investigation conducted on 5/21/09-5/22/09 for New Mexico Regulations Governing Adult Residential Care Facilities 7.8.2 NMAC. One complaint was investigated: NM #27089 and was UNSUBSTANTIATED with no deficiencies cited.</p>	A 00	

EF
Scanned
07-27-09



Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **7-1-09**

STATE FORM *Manuel R. Duarte* 6899 G0G811 *Administrator* If continuation sheet 1 of 1