

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  2161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/21/2013
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NAME OF PROVIDER OR SUPPLIER  BROOKDALE PLACE OF ALBUQUERQUE #1	STREET ADDRESS, CITY, STATE, ZIP CODE 4900 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
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A 000	<p>Initial Comments</p> <p>A complaint investigation was completed for intake NM00029171 on 8/21/13 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was unsubstantiated with no deficiencies cited.</p>	A 000		
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KH 12/26/13

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HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Patricia S. Meyer</i>	<i>Assisted Living Director</i>	