

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2160	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 04/08/2011
NAME OF PROVIDER OR SUPPLIER NIGHT N GAIL ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7621 PROSPECT AVENUE 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 The following deficiencies are cited as a result of a complaint survey related to intake #27904 conducted on January 31, 2011, for the New Mexico State Requirements for Assisted Living Facilities for Adults 7 NMAC 8.2	{A 000}		

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

TITLE

(X6) DATE