Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2055	A. BUILDING: ______ B. WING ______	C 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VALENCIA	**300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108**

(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 An investigation was completed for intake NM00028570 on 01/18/13 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was Unsubstantiated. No deficiencies were cited. An investigation was completed for intake NM00028891 on 01/18/13 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was Unsubstantiated. No deficiencies were cited. An investigation was completed for intake NM00028910 on 01/18/13 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was Unsubstantiated. No deficiencies were cited. An investigation was completed for intake NM00028891 on 01/18/13 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was Unsubstantiated. No deficiencies were cited.	A 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE