

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/10/2014
NAME OF PROVIDER OR SUPPLIER TENDER HEART ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 4308 TULANE DRIVE NE ALBUQUERQUE, NM 87107		
(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 No deficiencies were cited during a complaint investigation survey completed on 04/10/14 for the New Mexico requirements for Assisted Living for Adults, 7.8.2 NMAC. Complaint # NM 29380 was substantiated.	A 000			

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

TITLE

(X6) DATE