

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/13/2018
NAME OF PROVIDER OR SUPPLIER ALBUQUERQUE UPTOWN ASSISTED LIVING, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7611 INDIAN SCHOOL RD NE 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 No deficiencies deficiencies were cited as a result of a Revisit/Follow-up survey completed on 03/13/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities The facility was found to be in substantial compliance.	A 000			

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

TITLE

(X6) DATE