

Division of Health Improvement

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|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>4103</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/28/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HAVEN CARE - BIRCH HOUSE</b> |                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5320 VAN CHRISTOPHER NE<br/>ALBUQUERQUE, NM 87111</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                         | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                               | Initial Comments<br><br>An Offsite Surveillance survey was conducted on<br>04/21/20, related to Covid 19 infection prevention<br>and control. No deficiencies cited. | A 000                                                                                             |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE