STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2260	A. BUILDING: _____ B. WING _____	R-C 12/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUENA VISTA SENIOR CARE	**8505 RANCHO SANTA FE PLACE NE ALBUQUERQUE, NM 87113**

(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 A Complaint investigation was completed for intake #NM00027967 for NMAC 7.8.2 regulations governing Assisted Living facilities. The Complaint was Unsubstantiated. However, deficiencies were cited as a result of the investigation. The alleged perpetrator was referred for placement on the Employee Abuse Registry.	{A 000}		