

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2207	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 03/29/2017
NAME OF PROVIDER OR SUPPLIER HILLDALE HOUSE (ACTIVE SOLUTIONS, INC)			STREET ADDRESS, CITY, STATE, ZIP CODE 14528 HILLDALE ROAD NE ALBUQUERQUE, NM 87123		
(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 Revisit/Follow-up survey was completed on 03/29/17 for survey dated 08/10/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. There were no deficiencies cited as a result of the survey.	{A 000}			

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

TITLE

(X6) DATE