

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/29/2020
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - BIRCH HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5320 VAN CHRISTOPHER NE ALBUQUERQUE, NM 87111		
(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 an revisit/follow-up survey completed on 06/29/20 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. The facility was found to be in compliance for Survey Event ID # QZKV11/QXKV12.	{A 000}		

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

TITLE

(X6) DATE