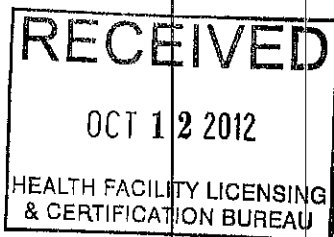


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2208	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2012
NAME OF PROVIDER OR SUPPLIER CASA PALO DURO (ACTIVE SOLUTIONS, INC)			STREET ADDRESS, CITY, STATE, ZIP CODE 7808 PALO DURO 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 A complaint investigation was completed for intake NM00028641 on 09/05/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was Unsubstantiated. No deficiencies were cited.	A 000 <i>Scanned 10-16-12 JV</i>			



Division of Health Improvement

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

STATE FORM

6899

644T11

TITLE

Facility Administrator

(X6) DATE

9/10/12
If continuation sheet 1 of 1