Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2208	A. BUILDING _____ B. WING _____	C 09/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA PALO DURO (ACTIVE SOLUTIONS, INC)	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 NM00028641on 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	Scanned 10-16-12 JV	

RECEIVED
OCT 12 2012
HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Bernadette Harrell — Facility Administrator — 9/18/12