Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5786	A. BUILDING _____ B. WING _____	05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLDALE RESIDENTIAL CARE HOME	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 00	NO DEFICIENCIES This Facility is in Compliance with all New Mexico Regulations Governing Adult Residential Care Facilities 7 NMAC 8.2. No deficiencies were cited on May 28,2009 for New Mexico Regulations Governing Adult Residential Care Facilities, NMAC 7.8.2.	A 00		

ES Scanned 06-04-09

RECEIVED JUN 2009 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Division of Health Improvement

Susan L. Cheshire — TITLE RN/Director (X6) DATE 6-1-09

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