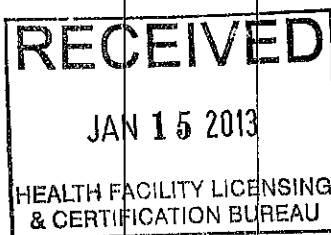


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/02/2013
NAME OF PROVIDER OR SUPPLIER CASA DE PAZ			STREET ADDRESS, CITY, STATE, ZIP CODE 4103 LAS CIMBRAS CT SE ALBUQUERQUE, NM 87124		
(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 An Initial survey was completed for NMAC 7.8.2 regulations governing Assisted Living facilities. No deficiencies were cited.	A 000			

*Scanned
1-16-13
JC*



Division of Health Improvement

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

TITLE *Administrator*

(X6) DATE *1/7/13*