STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5855	A. BUILDING _____ B. WING _____	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ADULT CARE HOME	7100 CARRIAGE ROAD NE ALBUQUERQUE, NM 87109

(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 #NM00028349 for NMAC 7.8.2 regulations governing Assisted Living facilities. The Complaint was Unsubstantiated.	A 000	Scanned 02-20-12 J.D.	

RECEIVED
FEB 2012
HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Owner — (X6) DATE: 2-7-2012

ORIGINAL