

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2154	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2011
NAME OF PROVIDER OR SUPPLIER TENDER HEART ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4308 TULANE DRIVE NE ALBUQUERQUE, NM 87107		
(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 NM00027943. The Complaint was unsubstantiated with no deficiencies cited.	A 000 <i>Scanned 8/15/11 mC</i>		



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

STATE FORM

6898

QY8211

TITLE

(X6) DATE

Spencer Blake Owner 8/18/11

If continuation sheet 1 of 1