Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2190	A. BUILDING _____ B. WING _____	C 08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMARK AT UPTOWN (THE)	7201 PROSPECT PLACE 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 Complaint investigations were conducted for intake NM00028282 and intake NM00028476 on 08/02/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The two complaints were unsubstantiated with no deficiencies cited.	A 000	Scanned 08-31-12 J.O.	

RECEIVED
AUG 30 2012
HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Division of Health Improvement

B. Cynthia Green — TITLE Exec. Director — (X6) DATE 8/24/12

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