Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
1ST Original	5624	A. BUILDING _____ B. WING _____	09/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLAMAH HOUSE LTD CO	11601 BELLAMAH NE ALBUQUERQUE, NM 87112

(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 Surveyor: 22697 On 9/15/10 a complaint investigation was conducted for Intake # NM00026723. The complaint was unsubstantiated. An annual survey was also conducted on 9/15/10. The facility was found to be in substantial compliance with NMAC 7.8.2 ASSISTED LIVING FACILITIES FOR ADULTS. No Deficiencies	A 000		

ES Seamed 09-29-10

RECEIVED
SEP 2010
HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Director — (X6) DATE 9/23/10

STATE FORM 6899 TNQC11 If continuation sheet 1 of 1