

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>1st Original</i>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/23/2008
NAME OF PROVIDER OR SUPPLIER WELLESLEY CARE HOME, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3209 WELLESLEY COURT 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 00	NO DEFICIENCIES This Facility is in Compliance with all New Mexico Regulations Governing Adult Residential Care Facilities 7 NMAC 8.2. Surveyor: 22697	A 00			

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10-01-08*

Division of Health Improvement

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

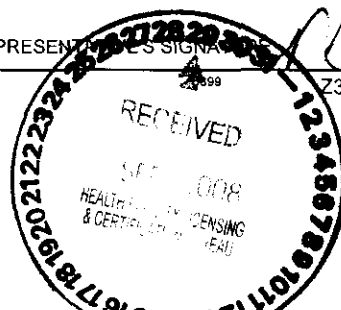
STATE FORM

TITLE

(X6) DATE

Z31F11

If continuation sheet 1 of 1



Michelle Keras / admin 9/25/08