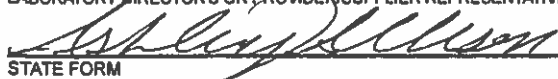


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/05/2018
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR OF ALBUQUERQUE		STREET ADDRESS, CITY, STATE, ZIP CODE 8051 PALOMAS AVE 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 No deficiencies were cited as a result of an Initial [REDACTED] survey completed on 04/05/18 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. [REDACTED] The facility was found to be in substantial compliance.	A 000		

Division of Health Improvement

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



TITLE

Executive Director

(X6) DATE

5/1/18