Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4016	A. BUILDING: **01** B. WING _____	**11/30/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIO ASSISTED LIVING	**13101 CONSTITUTION AVE 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 On November 29, 2016 an initial life safety code survey was conducted at the above referenced facility, as per the provider's request. At that time temporary licensure was not recommended. On December 7, 2016 an onsite revisit survey was conducted, all issues previously noted have been addressed and corrected. The facility is found in substantial compliance with the Life Safety Code Portion of the New Mexico State Regulations requirements for Assisted Living Facilities 7 NMAC 8.2 Temporary licensure of the facility is recommended.	A 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE