

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/17/2020
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT 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 during an revisit/follow-up survey completed on 07/17/20 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.	{A 000}			

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

TITLE

(X6) DATE