Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2154	A. BUILDING: _____ B. WING _____	04/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING	**4308 TULANE DRIVE 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 001	7 NMAC 8.2.1 Issuing Agency ISSUING AGENCY: New Mexico Department of Health, Division of Health Improvement, Health Facility Licensing and Certification Bureau. [7.8.2.1 NMAC - Rp, 7.8.2.1 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Attempted to conduct an offsite surveillance survey on April 2, 2020, related to COVID 19 onfection prevention and control.	A 001		

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE