

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/10/2020
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - FIR HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 10405 LOS SUENOS NW ALBUQUERQUE, NM 87114		
(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 offsite revisit/follow-up survey completed on 08/10/20 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. The facility was found to be in compliance..	A 000		

Division of Health Improvement

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

TITLE

(X6) DATE