

Division of Health Improvement

|                                                     |                                                                          |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>2134</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/11/2013</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TWIN OAKS ASSISTED LIVING**

**3051 TWIN OAKS NW  
ALBUQUERQUE, NM 87120**

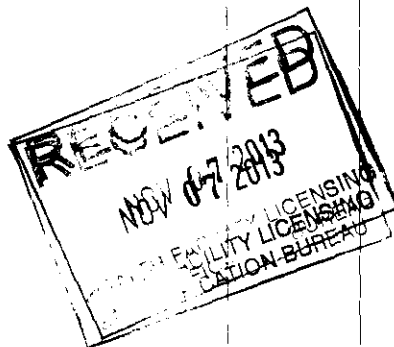
|                          |                                                                                                                              |                     |                                                                                                                          |                          |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|

A 000 Initial Comments

A 000

A Complaint investigations were conducted for intake NM 00029084 on 10/11/13 for the state requirements of 7 NMAC 8.2 Regulations for Assisted Living. The complaint was Unsubstantiated with No Deficiencies cited.

Scanned 11/8/13  
KH



Division of Health Improvement  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Handwritten Signature]*

TITLE

*[Handwritten Title]*

(X6) DATE

*[Handwritten Date]*