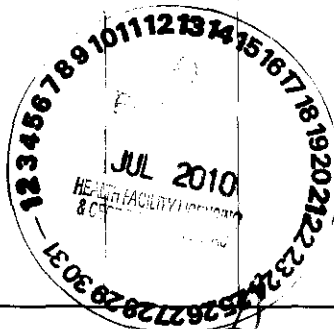


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2010
NAME OF PROVIDER OR SUPPLIER WILLOW WOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1008 CHIRICAHUA SE ALBUQUERQUE, NM 87123		
(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 00	NO DEFICIENCIES This Facility is in Compliance with all New Mexico Regulations Governing Adult Residential Care Facilities 7 NMAC 8.2. A complaint survey was conducted with no deficiencies cited for Complaint Intake # NM00027553 on 06/15/10.	A 00			

*ES
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07-15-10*



Division of Health Improvement

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

Dynna Blake Owner TITLE: *Owner* (X6) DATE: *7/7/10*

STATE FORM

6899

8 MIN 11

If continuation sheet 1 of 1