

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2008
NAME OF PROVIDER OR SUPPLIER TWIN OAKS ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3051 TWIN OAKS NW ALBUQUERQUE, NM 87120		
(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. No deficiencies were cited on August 18, 2008 for New Mexico regulations governing Adult Residential Care Facilities, NMAC 7.8.2.	A 00		

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If deficiencies are cited, an approved plan of correction is required for continued program participation.

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

TITLE

(X6) DATE

STATE FORM

D6P811

If continuation sheet 1 of 1

