

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2134	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TWIN OAKS ASSISTED LI' B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2008
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. Surveyor: 21700 On June 12, 2008 an initial Life Safety Code survey was conducted at the facility. This facility is found to be in compliance with the Life Safety Code portion of New Mexico State Regulations governing requirements for Adult Residential Care Facilities NMAC 7.8.2	A 00			

Division of Health Improvement

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

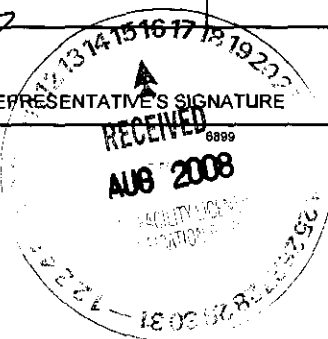
STATE FORM

TITLE

(X6) DATE

GNJT21

If continuation sheet 1 of 1



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Assessed
08-20-08*

6/15/08