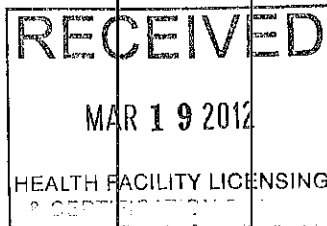


Division of Health Improvement

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 C 01/19/2012
NAME OF PROVIDER OR SUPPLIER TWIN OAKS ASSISTED LIVING			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 000	Initial Comments The following survey is the result of a complaint investigation completed for intake NM28284 on 01/19/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The complaint was substantiated with no deficiencies cited.	A 000 <i>Scanned 03-22-12 J.D.</i>			



Division of Health Improvement

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

TITLE

(X6) DATE

STATE FORM

6899

HRQU11

If continuation sheet 1 of 1