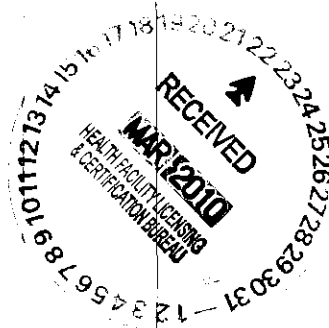


Division of Health Improvement

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 02/10/2010
NAME OF PROVIDER OR SUPPLIER TWIN OAKS ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3051 TWIN OAKS DRIVE 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 01	OPENING REMARKS Two (2) complaint investigations were completed on 2/10/2010 for NMAC 7.8.2-New Mexico Regulations Governing Adult Residential Care Facilities. 1. Intake # NM00027458 was UNSUBSTANTIATED 2. Intake # NM00027327 was UNSUBSTANTIATED.	A 01		



Division of Health Improvement

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

STATE FORM

6899

KM2111

TITLE

(X6) DATE

If continuation sheet 1 of 1

ORIGINAL