Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2134	A. BUILDING _____ B. WING _____	C 02/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN OAKS ASSISTED LIVING FACILITY	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		

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RECEIVED MAR 2010 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Division of Health Improvement

[redacted] Director TITLE

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

(X6) DATE 3/8/10

ORIGINAL