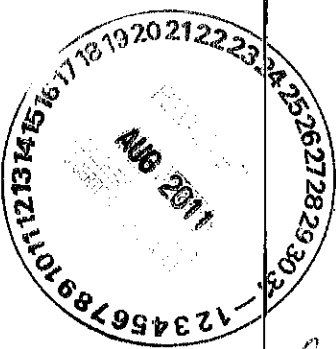


PRINTED: 08/18/2011
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2011
NAME OF PROVIDER OR SUPPLIER WILLOW WOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 CHIRICAHUA SE ALBUQUERQUE, NM 87123		
(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 A complaint investigation was completed for intake NM00027674. The Complaint was unsubstantiated with no deficiencies cited.	A 000 <i>Scanned 8/29/11 mc</i>		



Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	<i>Lynne Blake</i>	TITLE	<i>Owner</i>	(X6) DATE	<i>8/21/11</i>
STATE FORM	6899	PIJ611	If continuation sheet 1 of 1		