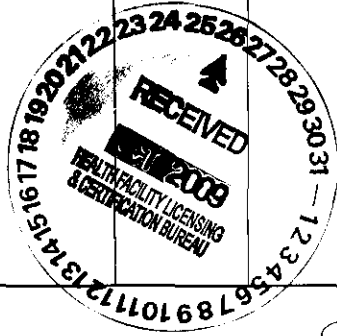


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5794	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2009
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NAME OF PROVIDER OR SUPPLIER WOODMARK AT UPTOWN (THE)	STREET ADDRESS, CITY, STATE, ZIP CODE 7201 PROSPECT PLACE NE ALBUQUERQUE, NM 87110
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(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.	A 00		
A 01	OPENING REMARKS Complaint #NM00027191 - Unsubstantiated	A 01 <i>ES Scanned 10-27-09</i>		



Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Sharon A. Dunbar* TITLE: *Executive Director* (X6) DATE: *10-21-09*