

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5788	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2010
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NAME OF PROVIDER OR SUPPLIER VILLAGE AT NORTHRISE-MORNINGSIDE (THE)	STREET ADDRESS, CITY, STATE, ZIP CODE 2880 N ROADRUNNER PARKWAY LAS CRUCES, NM 88011
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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 01	<p>OPENING REMARKS</p> <p>A complaint investigation was completed for intake number NM00027573. The complaint of unsanitary practices was unsubstantiated. No defeciencies were cited.</p>	A 01		

Division of Health Improvement LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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