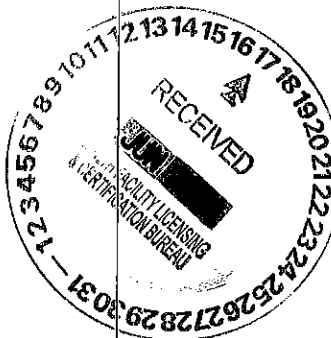


Division of Health Improvement

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 01/11/2011
NAME OF PROVIDER OR SUPPLIER VILLAGE AT NORTHRISE-MORNINGSIDE (THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2880 N ROADRUNNER PARKWAY LAS CRUCES, NM 88011		
(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)	(X6) COMPLETE DATE
A 000	Initial Comments A complaint investigation was completed for intake NM00027830. The Complaint was substantiated with no deficiencies cited.	A 000	scanned 6.21.11 CP	



Division of Health Improvement

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

[Signature] TITLE

(X6) DATE
6/16/11