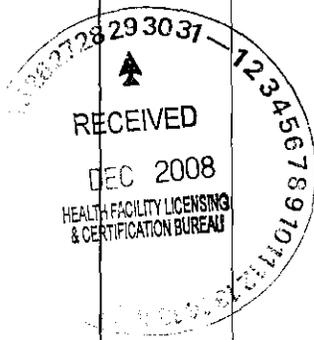


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>1st Original</i>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5789	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2008	
NAME OF PROVIDER OR SUPPLIER VILLAGE AT NORTHRISE - DESERT WILLOW I		STREET ADDRESS, CITY, STATE, ZIP CODE 2884 N ROADRUNNER 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)	(X5) COMPLETE DATE
A 00	<p>NO DEFICIENCIES</p> <p>This Facility is in Compliance with all New Mexico Regulations Governing Adult Residential Care Facilities 7 NMAC 8.2.</p>	A 00	<p><i>Scanned 12/30/08 m</i></p> 	

Division of Health Improvement

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

[Handwritten Signature]

TITLE

[Handwritten Title]

(X6) DATE

12/20/08