

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5788</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VILLAGE AT NORTHRISE-MORNINGSIDE (THE)</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2880 N ROADRUNNER PARKWAY LAS CRUCES, NM 88011</b>
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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 000	<p>Initial Comments</p> <p>A complaint investigation was completed for intake NM00028210 on 03/07/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was unsubstantiated with no deficiencies cited.</p>	A 000		

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