

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 08/21/2023
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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
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A 000	<p>Initial Comments</p> <p>No deficiencies were cited during an onsite Complaint survey completed on [REDACTED] 23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults.</p> <p>[REDACTED] was investigated with no deficiencies cited.</p> <p>Resident Census is 73.</p>	A 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Leah [Signature]

TITLE

Center Executive Director

(X6) DATE

8/28/2023