Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4003	A. BUILDING: _____ B. WING _____	R 11/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORHOOD IN RIO RANCHO (THE)	**900 LOMA COLORADO BLVD NE RIO RANCHO, NM 87124**

(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}	Initial Comments A Revisit survey was conduction on 11/30/16 for an Initial survey dated 10/03/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The facility was found to be in compliance. The following deficiency was cited as a result of an Initial survey completed on 10/03/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.	{A 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE