

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2282	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/30/2020
NAME OF PROVIDER OR SUPPLIER PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 & 1003 TRIBAL RD #140 ISLETA, NM 87022		
(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 An Offsite Surveillance survey was conducted on 03/30/20 related to CoVID-19 infection prevention and control. No deficiencies were cited.	A 000		

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

TITLE

(X6) DATE