Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 The following deficiencies were cited as a result of a Revisit/Follow-up survey completed on 04/10/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.	{A 000}	This Plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, The Pueblo of Isleta Assisted Living & Memory Care does not admit that the deficiency listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility enter reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. Please accept this plan of correction as the facility credible allegation of compliance with the certification requirements established in [NMAC 7.8.2.12(B)(5)].	
{A 016}	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant	{A 016}	A016 Corrective Action: New Employee inquiries to the Employee Abuse will be completed and available within 10-days prior to their date of hire. Monitoring: The administrator will audit and ensure a copy of the inquiry is available on the date of hire. If the employee does not have their inquiry completed, the employee will not be placed on the schedule until their inquiry is completed. Date of Completion: 05/01/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 016}	Continued From page 1 training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	{A 016}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 016}	Continued From page 2 7.8.2.16 B (3) This is an uncorrected deficiency from Survey dated 06/29/16 Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the	{A 016}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 016}	Continued From page 3 provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per	{A 016}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 016}	Continued From page 4 instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] Based on record review and interview the facility failed to ensure for 1 (DCS #1) of 1 (DCS #1) Direct Care Staff reviewed for pre-employment requirements had the Employee Abuse Registry (EAR) submitted prior-to-hire. This deficient practice could affect the safety and welfare of all 11 (R #s 1-11) residents identified on the census provided by the Administrator on 04/10/17, by being provided care by staff who may have a previous history of abusing, neglecting, or exploiting residents and/or is a convicted felon. The findings are: A. Record review of the DCS #1's file (hire date 02/18/17) revealed that the EAR was submitted on 03/16/17, not prior to hire. B. On 04/10/17 at 2:30 pm, during an interview with the Administrator, she confirmed that the EAR was submitted on 03/16/17, for DCS #1 and not submitted prior to hire.	{A 016}		
{A 025}	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident	{A 025}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 025}	Continued From page 5 changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and	{A 025}	A025 Corrective Action: R#1's evaluation was completed, signed and dated by a licensed physician extender. New resident evaluations will be completed, signed, and dated by a licensed nurse or physician extender within 15-days prior to admission, and will be kept in the resident's current chart. Monitor: The Administrator will audit all new residents within 15 days prior to admission to ensure resident evaluations are completed, signed, and dated by a licensed nurse or physician extender. The Administrator will also audit residents' charts to ensure that the evaluations and proper documentation is kept in the residents' charts. Date of Completion: 05/01/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 025}	Continued From page 6 if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A This is a uncorrected deficiency from survey 06/29/16 Based on record review and interview, the facility failed to ensure for 1 (R #1) of 1 (R #1) resident whose file was reviewed for compliance had an evaluation available for review. This deficient practice has the potential for the residents to not receive the appropriate care and services needed if the evaluations are not completed. The findings are: A. Record review of R #1's resident file revealed, the evaluation was missing from the file. B. On 04/10/17 at 2:15 pm, during interview with the Administrator, she confirmed that R #1's evaluation was missing from the file and stated that she could not find the evaluation in her office.	{A 025}		
A 026	7 NMAC 8.2.26 Individual Service Plan	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 026	Continued From page 7 INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC,	A 026	Corrective Action: R#1's ISP was developed with the hospice agency that was elected. Monitor: The Administrator will audit in-house residents ISPs to ensure that they are completed within 10 days of admission, and also reviewed every 6 months or when there is a significant change with the resident's health. Date of Completion: 05/01/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 026	Continued From page 8 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A Based on record review and interview, the facility failed to ensure for 1 (R #1) of 1 (R #1) resident receiving hospice services starting 01/11/17, had an Individual Service Plan (ISP) available for review. This deficient practice has the potential for the resident to not receive the appropriate care and services needed if the ISP is not available for the staff. The findings are: A. Record review of R #'s 1 file revealed, that there was no ISP in her file. B. On 04/10/17 at 2:15 PM, during interview with the Administrator, she confirmed that R #1's ISP was missing from the file because they did not complete one and that the facility has been using the [Name of Hospice Agency] Clinical Summary document dated 01/11/17, as the facility ISP.	A 026		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 035	Continued From page 9 the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises.	A 035	Corrective Action: Residents' MARs will be properly noted with the proper information: Resident's name, any known allergies, name of PCP, the diagnosis for the medication, the name of the medication, the dosage of the medication, the strength of the medication, the frequency or how often the medication is taken or given, the route of delivery of medication, the method of delivery of medication, the date the medication was started or discontinued, any change in the medication order, the date and time that the medication is self-administered or administered with assistance, the initials and signature of the person assisting with the medication, any refused dose or missed dose of the medication, and any medication error. Monitor: The Administrator and Facility Pharmacist will audit all residents' MARs to ensure that all appropriate information is noted correctly, and will have monthly reviews when the MARs are printed from the in-house pharmacy. Date of Completion: 05/01/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 035	Continued From page 10 Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order;	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 035	Continued From page 11 (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 035	Continued From page 12 the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (3) (4) (5) (12) Based on record review and interview, the facility failed to ensure that for 1 (R #1) of 1 (R #1) resident whose MAR was reviewed for accuracy had included the name R #1's Primary Care Physician or whomever prescribed the medication, the reason for taking the medication, the brand/generic name of the medication and the start/stop date for the medication. These deficient practices could possibly harm the resident if staff do not know; who prescribed the medication in case of a drug interaction, the reason for taking the medication, the brand or generic name and the start or stop date of the medication. The findings are; A. Record review of R #1's MAR's revealed the following; 1. Aspirin 81 mg (milligrams) Tablet (reduce fever and relieve mild to moderate pain), Chewable: No diagnosis and no name of who prescribed the medication. 2. Daily Vitamin tablet - (used to maintain or	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING. _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 035	Continued From page 13 boost health). No name of who prescribed the medication. 3. Levothyroxine 50 mcg (micrograms) tablet (a thyroid medicine that replaces a hormone normally produced by your thyroid gland to regulate the body's energy and metabolism): No diagnosis and no name of who prescribed medication. 4. Pantoprazole 40 mg tablets (used to treat gastroesophageal reflux disease (GERD): No diagnosis and no name of who prescribed the medication. 5. Vitamin D3 1000 units tablets (an essential vitamin that can be taken as a supplement to improve overall health or used to treat osteoporosis): No diagnosis and no name of who prescribed the medication. 6. Brimonidine Tarttrate 0.15% drops (an antiglaucoma medication used to treat open-angle glaucoma or ocular hypertension (high pressure inside the eye): No diagnosis, no name of who prescribed the medication. 7. Cal-gest 500 mg tablets, (used to treat symptoms caused by too much stomach acid such as heartburn, upset stomach, or indigestion): No diagnosis and no name of who prescribed the medication. 9. Gabapentin 100 mg capsule (Nerve pain medication and anticonvulsant): No diagnosis and no name of who prescribed medication. 10. Vitamin C 500 mg Tablets (Nutritional supplement): No diagnosis and no name of who prescribed the medication.	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 035	Continued From page 14 11. Gabapentin 300 mg (Nerve pain medication and anticonvulsant): No diagnosis and no name of who prescribed medication. 12. Mirtazapine 7.5 mg tablets (antidepressant): No diagnosis and no name of who prescribed the medication. 13. Metamucil (laxative) 1 tablespoon with 4 ounces water: No generic/brand name, no diagnosis and no name of who prescribed the medication and no start/stop date. 14. Hyoscyamine 0.125 mg PRN (as needed) (used to treat many different stomach and intestinal disorders): No generic/brand name and no diagnosis and no name of who prescribed medication. 15. Senna 8.6 mg tablets, (laxative): No brand/generic name, no name of who prescribed the medication. B. On 04/10/17 at 2:45 pm, during an interview with the Administrator, she confirmed that the MAR was missing the name of the Primary Care Physician or whomever prescribed the medication, the reason for taking the medication, no start/stop date of the medication and the brand/generic name of the medication.	A 035		
{A 060}	7 NMAC 8.2.60 Fire Clearence and Inspections FIRE CLEARANCE AND INSPECTIONS: A. Written documentation of a facility's compliance with applicable fire prevention codes shall be obtained from the state fire marshal ' s	{A 060}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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 060}	Continued From page 15 office or the fire prevention authority with jurisdiction and shall be submitted to the licensing authority prior to the issuance of an initial license. B. The facility shall request an annual fire inspection from the local fire prevention authorities. If the policy of the local fire department does not provide an annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7.8.2.60 NMAC - Rp, 7.8.2.59 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.60 B This is a uncorrected deficiency from survey dated 06/29/16 Based on record review and interview, the facility failed to ensure that an annual fire inspection by the local Fire Authority (having jurisdiction) had been conducted. This deficient practice has the potential for all 11 (R #s 1-11) residents identified on the resident census list provided by the Administrator on 04/10/17, to be at risk of injury or death if a fire occurs. The findings are: A. Record review request for annual fire inspections revealed that there had not been an inspection done for the year 2016. B. On 04/10/17 at 2:45 pm, during interview with the Administrator, she confirmed that the fire inspection was not done for the year 2016.	{A 060}	A060 Corrective Action: The POI Fire Chief or BCFD Fire Marshall will conduct an annual inspection. Monitor: The Administrator will continue to monitor until the fire inspection is completed. Date of Completion: 05/12/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2282	A. BUILDING: _____ B. WING _____	R 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE	1001 & 1003 TRIBAL RD 40 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