

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 R 05/17/2017
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 A Revisit/Follow-up survey was completed on 05/17/17, for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. There were no deficiencies cited and the facility was found to be in substantial compliance.	{A 000}			

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

TITLE

(X6) DATE