

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5712	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2009
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NAME OF PROVIDER OR SUPPLIER SENIOR LIVING SYSTEMS THOMAS RD	STREET ADDRESS, CITY, STATE, ZIP CODE 05 THOMAS ROAD LOS LUNAS, NM 87031
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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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A24	<p>7 NMAC 8.2.24 Pets</p> <p>7.8.2.24 PETS: Pets are permitted in a licensed facility, in accordance with the facility's rules.</p> <p>A. Pets are not permitted in the kitchen or food preparation areas.</p> <p>B. Pets shall be vaccinated in accordance with all state and local requirements and records of such vaccination shall be kept on file in the facility [7-11-86, 4-7-97; 7.8.2.24 NMAC - Rn, 7 NMAC 8.2.24, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Refers to NMAC 7.8.2.24 B.</p> <p>Based on record review and interview, the facility failed to ensure that documentation of vaccination was available for the 1 of 1 resident pets (P#1). The findings are:</p> <p>A. On 05/18/09 at 10:30 am, during review of the facility records, no evidence of vaccinations for P#1, was found.</p> <p>B. During interview on 05/18/09 at 10:30 am with the care coordinator, she acknowledged there was no vaccination record to be found.</p>	A24	<p><i>Scanned 6-1-09 JM</i></p> <p>PLAN OF CORRECTION</p> <p>1. Missing vaccination document for P#1 was immediately located and posted in a more conspicuous place along with all state licensing documents posted.</p> <p>2. All pets belonging to future residents will be posted in a place easily located and accesible for review.</p> <p>3. Administrator will request all future pet vaccination records prior to resident move in and ensure documents are posted for review.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE **Administrator** (X8) DATE **5/25/09**

STATE FORM 6899 32971 If continuation sheet 1 of 1