STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BUILDING: _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	**800 JUAN ANDRES LANE LOS LUNAS, NM 87031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG 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 during a Complaint(s) survey completed on 04/08/21 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake #'s 43539 was unsubstantiated with no deficiencies cited. 48865 was unsubstantiated with no deficiencies cited. 49735 was unsubstantiated with no deficiencies cited. 51222 was unsubstantiated with no deficiencies cited.	A 000		
A 026	7 NMAC 8.2.26 Individual Service Plan 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	A 026		

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A 026	Continued From page 1 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, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (3) Based on record review and interview the facility failed to ensure for 3 (R #s 2-4) of 4 (R #s 1-4) residents whose chart and Individual Service Plans (ISPs) were reviewed for compliance had been updated/revised and signed every 6 months or when a significant change in residents health occurred. This deficient practice could negatively affect the health and safety of the residents, if the Direct Care Staff (DCS) do not know what care/services they need to provide, because the ISPs did not reflect the current care/service needs of the residents. The findings are: A. Record review of R #2's chart revealed an unsigned assessment completed on 11/04/20,	A 026		

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A 026	Continued From page 2 however, there was no documentation to show that any ISPs were completed since [redacted] admission date of [redacted]/20. B. Record review of R #3's chart/ISP revealed 2 assessments, but only one ISP completed on 04/01/20. According to the self reported incident dated 12/07/20, R #3 returned from the hospital to the facility on 12/10/20 and was bedridden, however, there was no documentation that the ISP was reviewed, revised, or signed at a minimum of every 6 months or when a change in condition occurred. C. Record review of R #4's chart revealed an unsigned assessment done on 11/11/20, however, there was no documentation record to show that an ISP was completed in 2019 or 2020. [redacted] admission date was [redacted]/19. D. On 04/08/20 at 5:00 pm, during an interview with the Administrator, she confirmed that R #s 2-4 ISPs were missing or had not been reviewed, revised, signed, or updated at a minimum of every 6 months or when a change of condition occurred.	A 026		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The	A 034		

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A 034	Continued From page 3 facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II	A 034		

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A 034	Continued From page 4	A 034		

through IV drugs;
(b) the date and time staff assisted with self-administration;
(c) the resident ' s name;
(d) the prescriber ' s name;
(e) the dose;
(f) the signature of the person assisting with delivery of the medication; and
(g) the balance of medication remaining.
(9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC.
(10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility.
B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance.
(1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours.
(2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation.
(3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases

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A 034	Continued From page 5 involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7) refer to NFPA (National Fire Protection Agency) 99. 11.3 Cylinder and Container Storage Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and	A 034		

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A 034	Continued From page 6 nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection caps shall comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall	A 034		

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A 034	Continued From page 7	A 034		

comply with the requirements
in 11.3.3.1 and 11.3.3.2.
11.3.3.1 Individual cylinder storage associated with patient care
areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not
be required to be stored in enclosures.
11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1
shall be in accordance with 11.6.2.
11.3.3.3 When small-size (A, B, D, or E) cylinders are in use,
they shall be attached to a cylinder stand or to medical equipment
designed to receive and hold compressed gas cylinders.
11.3.3.4 Individual small-size (A, B, D, or E) cylinders available
for immediate use in patient care areas shall not be considered
to be in storage.
11.3.3.5 Cylinders shall not be chained to portable or movable
apparatus such as beds and oxygen tents.
11.3.4 Signs.
11.3.4.1 A precautionary sign, readable from a distance of
1.5 m (5 ft), shall be displayed on each door or gate of the
storage room or enclosure.
11.3.4.2 The sign shall include the following wording as a
minimum:
CAUTION:
OXIDIZING GAS(ES) STORED WITHIN
NO SMOKING
2012 Edition

Based on observation, and interview, the facility failed to ensure for 1 (R #6) of 1 (R #6) resident

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A 034	Continued From page 8 who uses oxygen that there was an "oxygen in use" sign on the outside of the room door. This deficient practice could likely result in the residents being at risk of harm, injury, or death, if there are no "oxygen in use" signs posted outside the room and a fire were to occur or 1st responders are not aware there is oxygen in use that could accelerate the fire. The findings are: A. On 04/08/21 at 10:40 am, during observation of R #6's resident room (room #1), [redacted] was being stored by the entrance door, inside the room, and there was no [redacted] observed posted on the outside of the door. B. On 04/08/21 at 10:44 pm, during an interview with the Administrator, she confirmed that there was [redacted] stored in R #6's resident room (#1) who uses [redacted] in the room, and there was no [redacted] sign posted on the outside of the door.	A 034		
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed	A 038		

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A 038	Continued From page 9	A 038		

metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms.
C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC.
[7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.38 A

Based on observation and interview the facility failed to ensure that all interior areas of the facility were kept clean, sanitary, free from safety hazards.

This deficient practice has the potential for the 8 (R #'s 1-8) residents, listed on the census provided by the Administrator on 04/07/21. to be at risk of harm, illness, or death if they were exposed to germs and bacteria, due to areas in the facility not being kept clean and sanitary.

The findings are:

Findings related to the bathrooms:

A. On 04/07/21 at 12:25 pm, during observation, 4 bathrooms in unoccupied rooms and one (1) occupied room (#1) were observed to be dirty with unflushed toilets, urine on toilet seats, and

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A 038	Continued From page 10 the floor. B. On 04/08/20 at 10:29 am, during an interview with the Administrator she confirmed that the toilets were dirty, unflushed, with urine stains on toilet seats and floors.	A 038		