STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4125	A. BUILDING: _____ B. WING _____	01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODLIFE SENIOR LIVING AND MEMORY CARE	2013 W18TH ST PORTALES, NM 88130

(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 an Initial survey completed on 01/21/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.	A 000		
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		

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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		

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A 016	Continued From page 2 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 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	A 016		

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A 016	Continued From page 3 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 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]	A 016		

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A 016	Continued From page 4 7.8.2.16. B (3) (7) Based on record review and interview, the facility failed to ensure that the Direct Care Staff, (DCS): 1. Received clearances from the Employee Abuse Registry (EAR) prior to hire. 2. Had their applications and fingerprints for the Caregivers Criminal History Screening Program (CCHSP) submitted within 20 days of hire. These deficient practices could likely negatively affect the safety and welfare of the 4 (R #s 1-4) assisted living residents identified on the census provided by the Administrator on 01/19/22, if residents are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents, or a criminal history. The findings are: A. Record review of DCS #1's employee file (date of hire 11/19/20) revealed: 1. Fingerprint clearance application was not submitted. 2. EAR clearance was not submitted B. Record review of DCS #2's employee file (date of hire 02/12/21) revealed: 1. Fingerprint clearance application was not submitted until 12/02/21. 2. EAR clearance was not received until 11/22/21. C. Record review of DCS #3's employee file (date of hire 09/22/21) revealed: 1. Fingerprint clearance application was not submitted until 11/19/21.	A 016	1. All New hires will have their back ground Checks done and be entered into the EAR prior to hire and have their finger prints done within 20 days of hire. 2. The manger of the Home will NOT put New employees on the schedule to give direct care until the EAR has been Completed. The regional manager will oversee the schedule and	

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A 016	Continued From page 5 2. EAR clearance was not received until 11/19/21. D. On 01/19/22 at 9:40 am, during an interview with the Administrator, he confirmed that: 1. DCS #s 1-3 did not have her fingerprint clearance application submitted within 20 days of hire. 2. DCS #s 1-3 did not receive her EAR clearance prior to hire.	A 016	ensure this is being done. 3. Correction will be Completed on March 15th. 2022.	
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 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;	A 025		

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A 025	Continued From page 6 (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 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 Based on record review and interview the facility	A 025		

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A 025	Continued From page 7 failed to ensure for 4 (R #s 1-4) of 4 (R #s 1-4) current/former residents whose resident records were reviewed for compliance that their evaluations were completed within 15 days prior to admission and maintained in the resident charts. This deficient practice could likely result in the current/former residents listed on the resident census provided by the House Manager on 01/18/22, to not receive appropriate care/services upon admission to the facility if, the Direct Care Staff (DCS) were not aware of what the resident's needs and conditions are upon admission. The findings are: A. Record review of R #1's (admission date [redacted]21) resident records revealed, there was no evaluation in the chart available for review. B. Record review of R #2's (admission date [redacted]21) resident records revealed, there was no evaluation in the chart available for review. C. Record review of R #3's (admission date [redacted]21) resident records revealed, there was no evaluation in the chart available for review. D. Record review of R #4's (admission date [redacted]21 resident records revealed, there was no evaluation in the chart available for review. E. On 01/21/22 at 12:00 pm, during an interview, the Manager, and Facility Registered Nurse (RN) confirmed that there was no documentation available that R #s 1-4's evaluations, were completed prior to admission.	A 025	1. All residents Evaluations are complete and current. All Evaluations will be done within 15 day prior to admission by the facility R.N. 2. The manager and regional manager will do regular Chart Audits to ensure that all evaluations are completed and current. And that they are in the Chart prior to admission. 3. This will be completed by March 15th 2022.	

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A 026	Continued From page 8	A 026		
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 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	A 026		

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A 026	Continued From page 9 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 (1) Based on record review and interview, the facility failed to ensure for 4 (R #s 1- 4) of 4 (R #s 1-4) residents whose Individual Service Plans (ISPs) were reviewed for compliance that they were: 1. Completed within 10 days of admission. 2. Included coordination of care with the Hospice and Home Health agencies. These deficient practices could likely result in the residents not receiving the higher level of care and services needed, because the Direct Care Staff (DCS) do not know what care/services they are to provide and what care/services the outside agency will provide if the ISP: 1. Was not completed within 10 days of admission. 2. Does not include coordination of care with the Hospice and Home Health agencies. The findings are: A. Record review of R #1's ISP dated 07/04/21 revealed it was not completed within 10-days after admission to the facility on [redacted]21. B. Record review for R #2's ISP dated 11/15/21 revealed it was not completed within 10-day of admission to the facility on [redacted]21.	A 026	1. All resident Individual Service Plans are completed and current and placed in Resident Charts. All care has been coordinated with Hospice and Home Health as well as our Caregivers. 2. All ISPs will be completed and placed in Resident Charts with in 10 days of admission by the facility Nurse. The Manager and Regional Manager will perform regular Chart Audits as well	

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A 026	Continued From page 10 C. Record review for R #3's ISP dated 07/13/21 revealed, no documentation that the ISP was updated when to include coordination of care with the hospice agency when [redacted] was admitted to hospice services on [redacted]/21. D. Record review for R #4's ISP dated 10/29/21 revealed it was not completed within 10-days of admission to the facility on [redacted]21 and it did not include, coordination of care with the Hospice provider(Hospice admission date [redacted]21). E. On 01/21/22 at 12:00 pm, during an interview, the Manager and Facility Registered Nurse (RN) confirmed that there was no documentation that initial ISP's for R #s 1-4 were completed within 10-days of admission and that the ISPs for R #s 3 & 4 did not include coordination of care with their hospice providers.	A 026	Making sure the charts are Completed prior to Move in. They will coordinate care with outside agencies. 3. This will be completed by March 15th 2022.	
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a	A 032		

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A 032	Continued From page 11 copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1-2) B (1-3) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents	A 032		

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A 032	Continued From page 12 utilizing the division's incident report form consistent with the requirements of the division ' S incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure health, safety, and welfare for 3 (R #s 1-3) of 4 (R #s 1-4) residents whose Incident Reports were reviewed for compliance, that the facility reported all reportable incidents involving possible abuse, neglect, exploitation, injuries of unknown origin, falls with injury, elopement, hospitalization, or any other incident of unusual occurrences that the facility: 1. Filed an Incident Report with the Licensing Authority within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. 2. Conducted internal investigations and submitted a follow-up reports to the Licensing Authority within 5 business days of the date the incident occurred. These deficient practices could likely result in the residents to be at risk of harm, injury, and/or death, if reportable incidents occur and the facility failed to: 1. Report all reportable incidents to the	A 032		

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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
A 032	Continued From page 13 Licensing Authority 2. Investigate all incidents and submit a follow up report to the Licensing Authority, within 5 business days from the date the incident occurred. The findings are: A. Record review of R #1's Internal Incident report dated 12/19/221 at 9:18 pm, revealed that R #1 was found in the facility on the ground [redacted] Resident was sent to the emergency room, where it was discovered, [redacted] There was no documentation that, the: 1. Incident was reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend. 2. Facility conducted an internal investigation of the unwitnessed fall with injury. 3. Facility submitted an investigation/follow-up report to the Licensing Authority within 5 business days from the date the incident occurred. B. Record review of R #2's Internal Incident reports, revealed the following: 1. On 11/22/21 at 4:00 pm, R #2 left the facility, was [redacted] recognized R #2 and brought [redacted] back to the facility. 2. On 12/18/21 at 5:15 pm, R #2 [redacted] from the facility after a family member of another resident did not lock the door. R #2 [redacted] R #2 [redacted] 3. There was no documentation in the	A 032	1. All incedents that potentially affect the health, safety and welfare have been reported to the State. We will continue to report all reportable incidents with the Licensing authority with in 24 hours. We will also conduct an investigation and report follow up reports within 5 days. 2. The regional manager will ensure that the Manager and facility Nurse understand the importance of reporting incidents and will assist in this process. 3. This will be completed by March 15 2022.	

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	4125	A. BUILDING: _____ B. WING _____	01/21/2022

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A 032	Continued From page 14 11/22/21 or 12/18/21 that the facility a. Reported the incidents to the Licensing Authority within 24 hours or the next business day if a holiday or weekend, b. Conducted an internal investigation of elopement incidents. c. Submitted a investigation/follow-up report to the Licensing Authority within 5 business days from the date of the incident. C. Record review of R #3's Internal Incident report dated 12/01/21 at 8:03 am, revealed, that the resident was found on the bathroom floor with [redacted] Emergency Medical Services (EMS) were called. There was no documentation that the facility: 1. Reported the incident to the Licensing Authority within 24 hours or the next business day if a holiday or weekend; 2. Conducted an internal investigation of the fall. 3. Submitted an investigation/follow-up report to the Licensing Authority within 5 business days of the date the incident occurred. D. On 01/20/22 at 10:13 am, during an interview with the Manager, she confirmed, the incidents listed above for R #s 1-3, were not reported to the licensing authority.	A 032		
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 034		

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A 034	Continued From page 15 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 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	A 034		

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A 034	Continued From page 16 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 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.	A 034		

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A 034	Continued From page 17 (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 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) B (2) Refer to: NFPA (National Fire Prevention Association) 99. 2012 Edition. 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 18 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 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	A 034		

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A 034	Continued From page 19 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 (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. Based on observation and interview, the facility failed to ensure that: 1. Oxygen cylinder tanks were not stored in a room with combustibles (towels, sheets, and other bedding). 2. There was an accurate reconciliation of resident medications This deficient practice could likely result in all 9 (R #s 1-9) residents listed on the census provided by the Administrator on 01/18/22, to be at risk of harm, injury, or death if: 1. Oxygen cylinder tanks were to be knocked over and may act like a missile, and if a fire occurs, oxygen cylinder tanks stored with combustibles accelerates the fire. 2. If the facility fails to ensure there is an accurate reconciliation of residents medications,	A 034		

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A 034	Continued From page 20 resident may not get all their medications, as ordered by the physicians. The findings are: Finding related to oxygen A. On 01/18/22 at 3:18 pm, during observation, 7 unsecured oxygen tanks were found being stored in in the linen room with combustibles (towels, sheets, bedding) B. On 1/21/22 at 10:37 am, during an interview with the House Manager, she confirmed, that the 7 unsecured oxygen tanks were stored in the linen room with combustibles. Findings related to medications: C. On 1/21/22 at 9:13 am, during an observation of R #2's [redacted] D. Record review of R #2's Medication Administration Record (MAR) dated 12/23/21 through 01/21/22, revealed, that [redacted] E. On 01/21/22 at 10:55 am, during observation of R #2's [redacted] F. Record review of R #2's 12/11/21 through 01/21/22 MARs, revealed that [redacted]	A 034	1. All oxygen tanks have been moved from the linen closet and placed in the storage closet in a rack to prevent them from tipping over. A med Audit has been done by the facility Nurse and pharmacist All meds, orders, and counts have been corrected. The staff has been trained on the proper processed of med passing. 2. The Oxygen tanks will be checked regulary by the Manger to ensure they are properly stored. the facility Nurse will perform regular med cart Audits to ensure processes are being followed 3. This will be completed on March 15 2022.	

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A 034	Continued From page 21 [redacted] G. On 1/21/22 at 10:55 am, during observation of R #2's [redacted] H. Record review of R #2s MAR dated 12/06/21 through 01/21/22, revealed that [redacted] I. On 1/21/22 at 10:55 am, during observation of R #4's [redacted] J. Record review of R #4's MAR dated 12/06/21 through 01/21/22, revealed that [redacted] K. On 01/21/22 at 3:52 pm, during an interview with the Nurse, she confirmed there were extra and missing medications that could not be reconciled after review of the MAR and completing a medication count.	A 034		
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible.	A 047		

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A 047	Continued From page 22 B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.47 E Based on observation and interview the facility failed to ensure that all emergency lights in the facility were in working order. This deficient practice could likely result in the 9 (R #s 1-9) Assisted Living and Memory Care residents identified on the census provided by the Administrator on 01/18/22, to be at risk of harm, injury, or death, if there is a power outage or other emergency requiring evacuation occurs and the residents cannot see to safely exit the building.	A 047	1. All emergency lighting in currently in good operating Condition. 2. The facility Maintenance person will do weekly Checks of all emergency lighting and perform any repairs needed done. The manger will ensure that the maintenance person documents Emergency lighting checks. 3. This will be Completed on March 15 2022	

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A 047	Continued From page 23 The findings are: A. On 01/18/22 at 3:05 pm, during observation and testing of the facility's 1 emergency light located in the front entrance, failed to light up when tested. B. On 01/21/22 at 12:18 pm, during an interview with the House Manager, she confirmed that the facility's emergency light located in the hallway at the entrance of the facility was not in working order.	A 047		