

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 during a Complaint survey completed on 05/07/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living Facilities for Adults. Resident Census: █	A 000		
A 017	Complaint Intake NM █ was investigated with deficiencies cited. 7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or	A 017		
Brittany Gordon Administrator 05/28/2025				

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE STATE FORM 6899 3XIH11 If continuation sheet 1 of 25

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 017	Continued From page 1 exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 8.370.14.17 A B C (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) Based on record review and interview, the facility failed to ensure for 3 (Direct Care Staff [DCS] DCS #'s 1-3) of 3 (DCS #'s 1-3) staff whose training files were reviewed for compliance, received the required annual training's. This deficient practice has the potential for all residents listed on the facility census provided by the Administrator to be at risk of harm or injury if staff have not received the required orientation and /or annual training on proper methods of providing care and services. The findings are: A. Record review of DCS #1's (date of hire 04/15/25) staff file revealed, the record did not	A 017	Immediate action was taken to ensure all staff complete the annual training at each staff meeting to be in compliance with the state of New Mexico. Will in the future ensure that all staff complete the annual training at monthly staff meetings to be in compliance with the state of New Mexico. The Manager will ensure all staff have completed the annual training by having staff attend each monthly staff meeting.. Staff will complete a training test monthly. The Manager and the Assistant will ensure training is conducted month to month until all trainings are completed for the year for each staff member. Each monthly training will be filed in the employee's personnel file in the office along with the date of the training and the topic of the training. Each month the personnel files will be audited. Corrective Action is Complete.	05/28/2025

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 017	Continued From page 2 contain documentation of current annual training for 1. Smoking Policy for Staff, Residents, and Visitors B. Record review of DCS #2's (date of hire 04/30/25) staff file revealed, the record did not contain documentation of current annual training's for: 1. Minimum of 16 hours of supervised training prior to providing unsupervised care to residents. 2. Smoking Policy for Staff, Residents, and Visitors 3. Medication assistance, including the certificate of training for staff that assist with medication delivery. C. Record review of DCS #3 (date of hire 12/06/24) staff file revealed the record did not contain any documentation of current annual training's for: 01. Minimum of 16 hours of supervised training prior to providing unsupervised care to residents. 02. Fire safety and evacuation training 03. First aid 04. Safe food handling practices 05. Confidentiality of records and resident information 06. Infection control 07. Resident rights 08. Reporting requirements for abuse, neglect or exploitation 09. Smoking policy for staff, residents and visitors 10. Methods to provide quality resident care 11. Emergency procedures 12. Medication assistance, including the certificate of training for staff that assist with medication delivery 13. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist	A 017			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 017	Continued From page 3 with ISP's. D. On 05/07/25 at 10:38 am, during an interview, the Administrator confirmed there are incomplete records for annual training in the DCS 1, 2 and 3 files.	A 017			
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary;	A 021			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 021	Continued From page 4 (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility;	A 021			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 021	Continued From page 5 (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010]	A 021			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(X4) ID PREFIX TAG A 021	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG A 021	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE 05/28/2025
	Continued From page 6 This REQUIREMENT is not met as evidenced by: 8.370.14.21 A (2) (3) (4) B (1) Based on record review and interview, the facility failed to ensure for █ (R #2 and R #3) o █ (R's █) files to be organized and to contain an initial evaluation, initial Individual Service Plan (ISP), and have a physical examination report completed within 10 days of admission. This deficient practice has the potential for the facility to overlook the needs of all residents and risk not providing each resident with their individualized care. The findings are: A) Record review of R #3 physical file revealed the following: 1. Admission date of █. 2. An initial Evaluation was not completed 15 days prior to admission. 3. An Individual Service Plan (ISP) was not completed within 10 days of admission. B) Record review of R #2's physical file revealed the following: 1. Admission date of █. 2. A physical examination report was not completed 10 days of admission. 3. A physical examination was not been completed in the past six (6) months. C) On 05/07/25 at 12:34 pm, during an interview, the Administrator confirmed that R #3 did not have an initial Evaluation or ISP completed as well as R #2 did not having a physical		Immediate action was taken to ensure each resident chart contained an initial evaluation, initial Individual Service Plan, and have a physical examination report completed within 10 days of admission to ensure each resident is receiving individualized care. Will in the future ensure that each new resident chart has an initial evaluation, initial Individual Service Plan, and a physical examination report completed within 10 days of admission and additionally every 6 months to ensure each resident will receive individualized care. The Nurse and Manager will ensure an initial evaluation, initial Individual Service Plan, and physical examination report is completed within 10 days of admission and every 6 months. ALIS (Facility Application on the computer) will be monitored monthly to ensure all evaluations, ISP's, and physical examinations are completed for the month. Each resident's evaluation and ISP will be signed and dated by the nurse, manager, and the POA upon completion. The Nurse, Manager, or Assistant Manager will ensure all evaluations, ISP's, and physical examinations are monitored monthly and are filed in the proper location of each resident's chart upon completion and a monthly audit of each resident chart will be conducted, with an audit monthly of ALIS. Corrective action is complete.	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 021	Continued From page 7 examination report on file.	A 021			
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the	A 022			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 022	Continued From page 8 facility and the fire safety evaluation system (FSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies: (a) an emergency that affects just the facility; and (b) a region/area wide emergency; (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC; (12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and (13) vaccination records for pets in the facility. B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by	A 022			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 022	Continued From page 9 the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with	A 022			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 022	Continued From page 10 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident 's personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010]	A 022			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 022	Continued From page 11 This REQUIREMENT is not met as evidenced by: 8.370.14.22 B (2) (a) (b) Based on record review and interview, the facility failed to ensure for 1 (Direct Care Staff [DCS] #3) of 3 (DCS #'s 1-3) whose training files were reviewed for compliance, did not contain proof of a background check. These deficient practices have the potential for all residents listed on the facility census provided by the Administrator to be at risk if staff have not been properly vetted (investigate someone thoroughly) prior to providing care. The findings are: A. Record review of DCS #3 (date of hire 12/06/24) staff file revealed the record did not contain documentation of: 1. Caregiver criminal history screening 2. Employee abuse registry clearances B. On 05/07/25 at 10:38 am, during an interview with the Administrator. The Administrator confirmed that proper clearances were not in the DCS file. 7 NMAC 8.2.32 Reporting of Incidents	A 022	Immediate action was taken to ensure background checks are ran on all staff. Will in the future ensure a background check is completed on all new hires. The Manager will ensure proper clearances are conducted on all new hires at time of hire or prior to hire date. The Manager and Assistant will ensure that a criminal history screening and employee abuse registry is in each employee's file to provide proof of clearances. A monthly audit will be conducted of every staff file to ensure clearances are conducted properly. Corrective Action is Complete.	5/28/2025
A 032	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	A 032		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 12 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 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: 8.370.14.32 A REPORTING OF INCIDENTS A. The facility shall ensure (to make certain that something shall occur or be the case) that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 NMAC. (1) The facility shall also report any	A 032	Immediate action was taken to ensure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported to the State of New Mexico within five (5) business days of incident. Will in the future ensure to 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. The Nurse or Manager will be responsible for conducting and documenting the investigation of all incidents within five (5) business days to the State of New Mexico and shall submit a copy of the investigation report to the licensing authority. The staff will be trained by the nurse or manager to call the nurse and the manager after an incident occurs, trained to fill out an incident report, and trained to leave the report in the manager's office. The documentation will be filed in the office in the Incident Binder. Manager and the Nurse will ensure a copy of the report and the documentation, including the date and time, was submitted to the licensing authority, shall be maintained on file at the facility in the incident binder. All new incident reports will be monitored daily. Corrective Action is Complete.	05/28/2025

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 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. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a 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. Based on record review and interview, the facility failed to ensure for 2 (R#1 and R#2) of 2 (R#1 and R#2) residents that the facility report incidents of suspected abuse that had or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority (LA) within twenty-four (24) hours and conduct an internal investigation and submit an investigation follow-up report to the LA within five (5) business days from when an incident occurred. Based on record review and interview, the facility failed to report loss or theft of medication to the Health Care Authority within twenty-four (24) hours or the next business day if it was a holiday or weekend. This deficient practice has the potential for all residents identified on the census provided by the Administrator on 05/06/25 to be at risk of harm, illness, or injury if there is no oversight by the Licensing Authority. The findings are:	A 032		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 14 A. Record review of R #4's incident report revealed that on 04/29/25: 1. [REDACTED] were discovered to be missing from the resident medication cart. 2. A report was made on 04/29/25 to New Mexico Board of Pharmacy (RP00004536) theft or loss of drugs or devices. 3. A report (LLPD2500831-001) was made on 05/01/25 through the Los Lunas Police Department. B. Record review of complaint and incident tracking system confirmed that the above incident was not reported to the Health Care Authority C. On 05/06/25 at 10:40 am, during an interview, the Administrator confirmed that the above incident had not been reported to the Healthcare Authority.	A 032			
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other;	A 033			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 033	Continued From page 15 (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident 's medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private	A 033			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 033	Continued From page 16 correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney;	A 033			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 033	Continued From page 17 (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 8.370.8.33 D (11) (a) Based on observation and interview, the facility failed to ensure for 3 (R #'s 1-3) of 3 (R #'s 1-3) residents were frequently monitored and checked on at a minimum once every two hours per the Individual Service Plan (ISP) and Employee handbook. This deficient practice could likely result in residents being neglected by staff not addressing their ISPs in a timely manner. The findings are: A. On 05/06/25 at 5:30 am, an observation of	A 033	Immediate action was taken to ensure all residents are frequently monitored and checked at a minimum once every two hours to ensure residents are not neglected by staff. Will in the future ensure all residents are frequently monitored and checked at a minimum once every two hours to ensure residents are not neglected by staff. The Manager or Assistant will be responsible that staff are properly trained to document on a Q2 so residents are monitored and checked once every two hours. The Q2 will be monitored daily by the manager or assistant for every shift to ensure it is being completed. The Manager or Assistant will ensure a Q2 is completed on each shift to provide proof that each resident was monitored and checked once every two hours. The Q2 will be filed in the manager's office. Corrective Action is Complete.	05/28/2025

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 033	Continued From page 18 DCS #3 revealed the non-use of an incontinence (inability of the body to control the evacuative functions of urination or defecation) care tracking log. B. On 05/06/25 at 5:30 am, during an interview, DCS #3 confirmed the following: 1. As a caregiver she is required to check on residents once every two (2) hours. 2. Not maintaining an incontinence care tracking log at night as directed not to by management two weeks prior. 3. DCS #3 summarizes her night report on a phone app known as ALIS. 4. R #1's [REDACTED] is left unchanged for 4-5 hours during swing shift because R #1 is difficult to deal with. C. On 5/06/2025 at 9:46 am, during an observation of DCS #4 revealed the following: 1. DCS #4 arrived on shift at 7:00 am. 2. DCS #4 required checks on residents had not been documented as complete. D. On 5/06/25 at 10:30 am, during an interview, DCS #1 and DCS #4 advised the following: 1. The memory care unit is often short-staffed. 2. Due to lack of staff, residents are "left soiled and pooped for extended periods of time." 3. DCS #1 stated the last time she recalls a resident being left soiled was the previous week during the night shift. E. On 5/06/25 at 10:40 am, during an interview, the Administrator advised the following: 1. She assumed her role as Administrator one and one-half months ago. 2. The facility is short-staffed. 3. The "Good Life employee handbook" specifies for caregivers to comply with incontinence care	A 033			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 033	Continued From page 19 tracking care logs and check on residents at least once every two hours. F. Record review of R #3's assessment dated 5/6/25, indicates the following: 1. Staff will perform 2-hour checks and ensure that the call bell is within reach and that R #3 is encouraged to use it prior to ambulating (to move from place to place) or transferring. G. Record review of R #1's assessment dated 2/5/25, indicates the following: 1. Staff will perform 2-hour checks and ensure that the call bell is within reach and that R #1 is encouraged to use it prior to ambulating or transferring. H. Record review of R #2's assessment dated 1/20/25, indicates the following: 1. Staff will perform 2-hour checks and ensure that the call bell is within reach and that R #2 is encouraged to use it prior to ambulating or transferring. I. On 05/06/25 at 10:40 am, during an interview, the Administrator confirmed past instances of residents beeing left soiled for extended periods of time. 7 NMAC 8.2.34 Custodial Drug Permits	A 033			
A 034	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	A 034			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 034	Continued From page 20 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 separately for each schedule II through IV drug (controlled substances). The proof of use sheet	A 034			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 034	Continued From page 21 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. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including	A 034			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 034	Continued From page 22 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: 8.370.14.34 A (7) Reference NFPA 99, 1999 Edition Section 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations.	A 034	Immediate action was taken to ensure that all oxygen cylinders are protected from accidental damage or dislocation by placing them in a rack. Will in the future will ensure cylinders will be protected from accidental damage or dislocation by placing them in a rack. The Manager will train staff that all oxygen cylinders will be stored in a rack in each resident's closet. There will be a sign at the entrance of each resident's room indicating the resident is on oxygen. Staff will be trained to monitor that all oxygen tanks are in racks on each shift daily. The manager will ensure that residents have a rack available for storage of oxygen cylinders by requesting the rack from the source that needs to provide the rack. All oxygen cylinders will be placed in a rack. Corrective Action is Complete.	5/28/2025	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 034	Continued From page 23 Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7]. 6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. 7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)]. Based on observation, and interview, the facility	A 034			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2025
NAME OF PROVIDER OR SUPPLIER GOOD LIFE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 JUAN ANDRES LANE LOS LUNAS, NM 87031		
(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 034	Continued From page 24 failed to ensure that oxygen cylinder tanks were stored securely, protected from accidental damage or dislocation. These deficient practices have the potential for residents to be at risk of harm and/or serious injury if oxygen cylinder tanks were to fall over damaging the valve, causing it to depressurize, The findings are: A. On 05/06/25 at 8:54 am, during observation of R [REDACTED], two (2) unsecured oxygen cylinder tanks were observed to be stored in the room without proper tank racks or holder. B. On 05/06/25 at 8:57 am, during observation of [REDACTED] two (2) unsecured oxygen cylinder tanks were observed to be stored in the room without proper tank racks or holder. C. On 05/06/25 at 8:59 am, during observation of [REDACTED] two (2) unsecured oxygen cylinder tanks were observed to be stored in the room without proper tank racks or holder. D. On 05/06/25 at 8:59 am, during an interview, DCS #4 confirmed the oxygen cylinder tanks were not securely stored and stated that the supplier did not provide them.	A 034			