

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
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A 000	Initial Comments The following deficiencies were cited as a result of an Initial survey completed on 09/14/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.	A 000		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the	A 020		

Division of Health Improvement

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Improvement

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A 020	Continued From page 1 resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency;	A 020		

Division of Health Improvement

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A 020	Continued From page 2 (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall:	A 020		

Division of Health Improvement

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A 020	Continued From page 3 (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]	A 020		

Division of Health Improvement

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A 020	Continued From page 4 This REQUIREMENT is not met as evidenced by: Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the	A 020		

Division of Health Improvement

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A 020	Continued From page 5 responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them. C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately. Refer to 7.8.2.20 A (5) (12); and Senate Bill 0335 - 2013. Based on record review and interview, the facility failed to ensure for 4 (R #s 1-4) of 4 (R #s 1-4) residents that the Admissions Agreements reviewed were in compliance with state statutes for the following: 1. The facility eviction policy in the Admission agreement, does not include "if an appropriate placement is found for the resident." 2. The facility refund policy does not include refunds in accordance with state statutes. This deficient practice has the potential for residents, resident's estate, and/or resident's responsible party to be at risk of harm or financial hardship if: 1. Resident is discharged before an appropriate placement is found; 2. The resident's estate or responsible party suffers financial hardship by not receiving the refund that is due upon the resident's death. The findings are: A. Record review of the Admissions Agreements	A 020		

Division of Health Improvement

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A 020	Continued From page 6 for R #s 1 - 4 revealed the following: 1. There is no reference in the termination of the agreement and discharge policy that stipulates "if an appropriate placement is found for the resident." 2. The agreement states, "8) . . . Under no circumstances, including termination, discharge, transfer or eviction, will there be refund for any period. Should a death occur, room charges will be pro rated [sic] to seven (7) days after personal items have been removed by the family." B. On 09/14/17 at 9:03 am, during an interview with the Administrator, she confirmed that the resident discharge policy does not state, "if an appropriate placement is found for the resident." The administrator also confirmed that the refund policy, in the event of a resident's death, violates state statutes.	A 020		
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		

Division of Health Improvement

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A 032	Continued From page 7 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, B 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		

Division of Health Improvement

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A 032	Continued From page 8 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: 1. Report injuries of unknown origin and other events including, falls which may cause injury and/or unexpected death, to the Licensing Authority within 24 hours or the next business day if a holiday or weekend. 2. Submit a follow-up investigation report to the Licensing Authority within five (5) business days. These deficient practices have the potential for all 14 (R#s 1-14) residents, as identified on the census provided by the Administrator on 09/12/17, to be at risk of harm if injuries of unknown origin are not reported and investigated as required. The findings are: A. Record review of a facility Incident Report dated 05/18/17 for R #2 states, "Staff found R #2 on floor with a wound on forehead and leg." There was no documentation that the incident was reported to the Licensing Authority.	A 032		

Division of Health Improvement

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A 032	Continued From page 9 B. Record review of a facility Incident Report dated 07/07/17 for R #2 states, "Unwitnessed fall with head injury, ambulance was called, and she was treated at the Emergency Room." There was no documentation that the incident was reported to the Licensing Authority. C. Record review of a facility Incident Report dated 07/23/17 for R #4 states "[Resident's Name] was found on floor from an unwitnessed fall with minor injuries and was treated onsite by 911 responders." There was no documentation that the incident was reported to the Licensing Authority. D. On 09/13/17 at 10:35 am, during an interview with the Administrator, she confirmed that the three incidents were not reported to the Licensing Authority.	A 032		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements.	A 036		

Division of Health Improvement

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A 036	Continued From page 10 (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling;	A 036		

Division of Health Improvement

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A 036	Continued From page 11 (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing,	A 036		

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A 036	Continued From page 12 rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents.	A 036		

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A 036	Continued From page 13 (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin.	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2017
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A 036	Continued From page 14 (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 B (4) C (2) (d) (4) & F. National Fire and Protection Association (NFPA) 96, "Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
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A 036	Continued From page 15 (2011 Edition) 11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months. Table 11.4 Schedule of Inspection for Grease Buildup Type or Volume of Cooking Inspection Frequency ... Systems serving moderate-volume cooking operations - Semiannually Based on observation, record review, and interview, the facility failed to ensure that: 1. A daily log of the temperatures for the refrigerator/freezer and a monthly log for the dishwasher were recorded and maintained; 2. When a dishwashing machine is utilized, the cleanliness of the machine, its jets, and its thermostatic controls shall be monitored and documented by the facility; 3. The garbage/refuse container had a tight fitting lid when not in use; 4. The kitchen exhaust hood fire sprinkler system was inspected semi-annually (every 6 months); and 5. The kitchen exhaust hood was inspected for grease build up semi-annually (every 6 months) and cleaned at minimum yearly.	A 036			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/14/2017
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A 036	Continued From page 16 These deficient practices have the potential for all 14 (R #s 1-14) residents identified on the Resident Census provided by the Administrator on 09/12/17, to be at risk of contracting foodborne illnesses if the food is not stored at the proper temperatures, the dishwasher is not properly sanitizing the dishes and utensils, and the trash can does not have a tight fitting lid to avoid spills and contamination. All occupants in the building are in danger of harm if the kitchen exhaust hood is not maintained for protection to prevent a grease fire, or the sprinkler system is not working in case of a fire. The findings are: A. Record review of the facility's daily refrigerator and freezer temperature logs revealed that there was no recorded temperature logs available for review for the month of September. B. Record request of the facility's daily dishwasher temperature logs revealed that there were no recorded temperature logs available for review. C. On 09/13/17 at 2:30 pm, during observation, it was observed that the kitchen trash container lid did not fit tightly and would allow for spills and contamination of the food preparation area. D. On 09/13/17 at 2:45 pm, during an interview with the Administrator, she confirmed that the refrigerator and the freezer temperatures were not taken and recorded for the month of September. She also confirmed that the dishwashing temperatures were not taken and recorded, and there was no tight fitting lid for the kitchen trash can. E. On 09/14/17 at 10:30 am, during observation	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
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A 036	Continued From page 17 while on a tour of the facility, it was observed that the kitchen exhaust hood did not have a sticker posted on the hood to signify it was inspected for grease build up semi-annually (every 6 months) and cleaned at minimum yearly. F. Record review revealed only one inspection and service of the kitchen exhaust hood fire sprinkler system dated 06/01/17. There were no records to signify it had been inspected and serviced for the preceding year. G. On 09/14/17 at 10:30 am, during interview, the Administrator acknowledged there was no documentation to signify the kitchen exhaust hood fire sprinkler system had been inspected and serviced for the preceding year from the most recent inspection on 06/01/17 and there had not been inspections for grease build up or cleaning of the system.	A 036		
A 044	7 NMAC 8.2.44 Heating, Air-Conditioning and Ventilation HEATING, AIR-CONDITIONING AND VENTILATION: A. Heating, air-conditioning, piping, boilers and ventilation equipment shall be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities shall have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility shall provide a minimum temperature of seventy (70) degrees fahrenheit, measured at three (3) feet above the floor, in all rooms used by the residents.	A 044		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
(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 044	Continued From page 18 C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device shall be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances shall be permanently anchored and kept away from flammables such as curtains, bedcovering, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or presents danger from electrical shock. D. Fireplaces and open flame heating shall not be utilized in sleeping rooms. E. Gas fired water heaters shall not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. The facility shall be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means. G. All openings to the outside air used for ventilation shall be screened for the control of insects and rodents. Screen doors shall be equipped with self-closing devices. H. The facility shall have a system for maintaining the residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7.8.2.44 NMAC - Rp, 7.8.2.45 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.44 A Based on record review and interview the facility failed to ensure that the gas heating system was checked, tested, and maintained annually. This	A 044		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2017
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A 044	Continued From page 19 deficient practice has the potential for all 14 (R #s 1-14) residents identified on the census provided by the Administrator on 09/12/17, to be at risk of illness and harm if the furnace stops working during cold weather and/or has a gas/carbon monoxide leak. The findings are: A. Record request of the facility's maintenance file revealed that there was no documentation for annual inspections for the gas heater furnace. B. On 09/13/17 at 1:30 pm, during an interview with the Administrator, she confirmed that there was no documentation of any annual gas heater inspections available for review and could not confirm when the heater was last inspected.	A 044		
A 061	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction. B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room.	A 061		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
(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 061	Continued From page 20 (3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service. [7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2. 61 NFPA 72 - 2010 14.3 Inspection. 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. From table 14.3.1 Control equipment: fire alarm systems monitored for alarm, supervisory, and trouble signals: (a) Fuses; (b) Interfaced equipment; (c) Lamps and LEDs; (d) Primary (main) power supply, Annually. Based on record review and interview, the facility failed to ensure that the fire alarm inspection and testing forms and the testing of all components of the fire alarm system such as, pull stations, horns/strobes, smoke detectors, heat detectors, etc. are in accordance with and are properly documented as required by NFPA 72 (National Fire Alarm Code). Not properly testing and documenting all testing of individual components of the fire alarm system could result in components and devices being missed or unaccounted for during the testing, which	A 061		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
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A 061	Continued From page 21 presents the risk of potential harm to all 14 (R #1 - 14) residents as identified by a resident census list provided by the Administrator on 09/12/17 and all occupants of the building. The findings are: A. Record review of the facility's inspection records for the fire alarm system revealed no documentation of an annual inspection and testing of the alarm system for the past year [2016]. B. On 09/14/17 at 9:05 am, during interview, the Administrator confirmed she could not find any documentation of inspections or testing of the fire alarm system for 2016.	A 061		
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.62 & National Fire and Protection Association (NFPA) Reference NFPA 13 Section 1-5.1 Maintenance: A sprinkler system installed under this standard shall be properly maintained for efficient service. The owner is responsible for the condition of the	A 062		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
(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 062	Continued From page 22 sprinkler system and shall use due diligence in keeping the system in good operating condition. Reference: NFPA 13, Sect. 1-6.1 states that a building, where protected by an automatic sprinkler system installation, shall be provided with sprinklers in all areas. 25-12 INSPECTION, TESTING, AND MAINTENANCE OF WATER-BASED FIRE PROTECTION SYSTEMS 2011 Reference NFPA 25, 1-4.2 The responsibility for properly maintaining a water-based fire protection system shall be that of the owner(s) of the property. By means of periodic inspections, tests, and maintenance, the equipment shall be shown to be in good operating condition, or any defects or impairments shall be revealed. Inspection, testing, and maintenance shall be implemented in accordance with procedures meeting or exceeding those established in this document and in accordance with the manufacturer's instructions. These tasks shall be performed by personnel who have developed competence through training and experience. Reference NFPA 25, 1-4.4 The owner or occupant promptly shall correct or repair deficiencies, damaged parts, or impairments found while performing the inspection, test, and maintenance requirements of this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. Reference NFPA 25, 5.1	A 062			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
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A 062	Continued From page 23 5.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Based on record review, observation and interview, the facility failed to have documentation that the automatic fire protection (sprinkler) system had been tested and inspected quarterly and annually. This deficient practice has the potential for all 14 (R # 1-14) residents on the census provided by the Administrator on 09/12/17, to be at risk of injury or death, in the event of a fire, if the sprinkler system doesn't work properly. The findings are: A. Record request for the Annual/Quarterly Inspection Reports for the automatic fire protection (sprinkler) system revealed there was not documentation of the reports available for review by the Licensing Authority. B. On 09/13/17 at 9:55 am, during observation of the the manufacturer's annual/quarterly inspection tag located on the riser pipe (water supply to sprinklers) of the sprinkler system, revealed that the first quarterly inspection was conducted on 05/22/17 and that the second quarterly inspection, due in August 2017, was almost a month over due. C. On 09/14/17 at 9:05 am, during interview, the Administrator confirmed she could not find any documentation of inspections or testing of the sprinkler system and that the second quarterly inspection, due in August 2017, was past due.	A 062		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s)	A 063		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
(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 063	Continued From page 24 must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Reference NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition: 7.2 Inspection. 7.2.1 Frequency. 7.2.1.1* Fire extinguishers shall be manually inspected when initially placed in service. 7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. 4-3 Inspection.	A 063		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 063	Continued From page 25 Based on observation and interview, the facility failed to ensure that 6 (1 in kitchen and 5 throughout facility) of 6 portable fire extinguishers inspected for compliance were maintained in accordance with NFPA 10 Standard for Portable Fire Extinguishers. This failed practice may result in the failure of the portable fire extinguishers to operate, in the event of a fire and increases the potential risk of harm or injury to residents and staff if a fire were to occur and the fire extinguishers did not work. The findings are: A. On 09/13/17 at 3:00 pm, during observation of the kitchen fire extinguisher, revealed that the tag had not been signed as being inspected monthly. B. On 09/13/17 at 3:15 pm, during observation of the 5 fire extinguishers located throughout the facility, revealed that tags had not been signed as being inspected monthly. C. On 09/13/17 at 3:30 pm, during interview with the Administrator, she confirmed that staff had not been inspecting any of the facility fire extinguishers monthly, therefore not signing the inspection tags on the fire extinguishers. She stated that she was not aware they had to be inspected each month and thought the yearly inspection was sufficient.	A 063		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use	A 065		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
(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 065	Continued From page 26 of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.65 A B (2) Based on record review and interview, the facility failed to: 1. Have fire drills each month for the past year (September, 2016 through August, 2017); and 2. Conduct fire drills on each shift for each quarter for the past year. This failed practice may result in the staff not being prepared to conduct a safe evacuation of residents in the event of a fire. This has the potential to harm all 14 (R # 1-14) residents, as identified on the resident list provided by the Administrator on 09/12/17 and all occupants of the building. The findings are: A. Record review of the facility's fire drill records revealed the following: 1. There were no fire drills documented for	A 065		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 VISION DR RUIDOSO, NM 88345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 065	Continued From page 27 September 2016 to December 2016; and 2. There were no fire drills during the 1:45 pm to 10:00 pm shift from September 2016 to January 2017, and March 2017 to August 2017. B. On 09/14/17 at 9:00 am, during interview with the Administrator, she acknowledged: 1) There were no fire drills documented for September 2016 to December 2016; and 2) There were no fire drills on the 1:45 pm to 10:00 pm shift from March 2017 to August 2017.	A 065		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced	A 070		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/14/2017
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A 070	Continued From page 28 by: 7.8.2.70 F 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 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.	A 070		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/14/2017
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A 070	Continued From page 29 Based on record review and interview, the facility failed to: 1. Report injuries of unknown origin and other events including, falls which may cause injury and/or unexpected death, to the Licensing Authority within 24 hours or the next business day if a holiday or weekend. 2. Submit a follow-up investigation report to the Licensing Authority within five (5) business days. These deficient practices have the potential for all 14 (Residents 1-14) residents as identified on the census provided by the Administrator on 09/12/17, to be at risk of harm if injuries of unknown origin are not reported and investigated as required. The findings are: A. Record review of a facility Incident Report dated 05/18/17 for Resident #2 states, "Staff found Resident #2 on floor with a wound on forehead and leg." There was no documentation that the incident was reported to the Licensing Authority. B. Record review of a facility Incident Report dated 07/07/17 for Resident #2 states, [REDACTED] There was no documentation that the incident was reported to the Licensing Authority. C. Record review of a facility Incident Report dated 07/23/17 for Resident #4 states "[Resident's Name] was found on floor from an unwitnessed fall with minor injuries and was treated onsite by 911 responders." There was no documentation that the incident was reported to the Licensing Authority. D. On 09/13/17 at 10:35 am, during an interview with the Administrator, she confirmed that the	A 070		

Division of Health Improvement

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A 070	Continued From page 30 three incidents were not reported to the Licensing Authority.	A 070			