| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 000 | Initial Comments<br><br>A complaint investigation was completed on 10/09/13 for intake NM 00028875 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was unsubstantiated with a deficiency cited. | A 000 | | |
| A 035 | 7 NMAC 8.2.35 Medication<br><br>MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record.<br>A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals.<br>B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing.<br>C. PRN (pro re nada) medication.<br>(1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the | A 035 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 1 | A 035 | | |

circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified.
(2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP.
D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments.
E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur.
F. Medications prescribed for one resident shall not be used for another resident.
G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include:
(1) the resident's name;
(2) any known allergies to medication that the resident has;
(3) the name of the resident's PCP or the prescriber of the medication;
(4) the diagnosis or reason for the medication;
(5) the name of the medication, including the drug

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 2 | A 035 | | |

product brand name and the generic name;
(6) notation if the medication is a schedule II-IV drug;
(7) the dosage of the medication;
(8) the strength of the medication;
(9) the frequency or how often the medication is to be taken or given;
(10) the route of delivery for the medication (mouth, eye, ear, other);
(11) the method of delivery for the medication (pills, drops, IM injection, other);
(12) the date that the medication was started or discontinued;
(13) any change in the medication order;
(14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order;
(15) the date and time that the medication is self-administered, administered with assistance or is administered;
(16) the initials and signature of the person assisting with or administering the medication;
(17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.);
(18) any refused dose of medication;
(19) any missed dose of medication; and
(20) any medication error.
H. No medication shall be stopped or started without specific orders from the primary care physician.
I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.
J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 3<br>Documentation of the event shall be kept in the resident's record.<br>K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following:<br>(1) the resident's name;<br>(2) the name of the medication;<br>(3) the date that the prescription was issued;<br>(4) the prescribed dosage and the instructions for administration of the medication; and<br>(5) the name and title of the prescriber.<br>L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery.<br>M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record.<br>N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED).<br>[7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>This deficiency refers to 7 NMAC 8.2.35 A. B. and D:<br><br>Based on record review and interviews, the facility failed to ensure employees who were identified as actually "administering" medications such as [redacted] | A 035 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 4 | A 035 | | |

to 3 of 3 (R #1, 2, 3) residents, were licensed through the state board of nursing or were identified as certified health care professionals. This deficient practice resulted in 3 (R #1, #2, and #3) of 3 end of life hospice residents who were not able to self administer their own medications and who were receiving medications that were being administered to them by caregiver staff. The facility also failed to follow its own policy for assisting with medications. The findings are:

A. Record review and interviews for Resident R #1 revealed the following information:

1. Resident Assessment dated [redacted]/12 indicated, the resident had a primary diagnosis of [redacted] Resident also shows signs of [redacted] Resident has [redacted] and needs to be prompted...Does not know this is [redacted] home." It further indicated, "Unable to administer own medications...Facility to manage medications and give to resident on a timely basis ...It further indicated that written consent had been given by the guardian for staff to only "assist" with the residents medications."

2. Individual Service Plan (ISP) dated 11/23/12 indicated the resident was admitted to Hospice services on [redacted]/12. It further indicated [redacted] has [redacted]

3. Review of the Hospice care plan dated [redacted]/12 indicated the residents mental status was [redacted]

4. Physician Prescription dated [redacted]/12 indicated, [redacted]

5. A communication form (no date) from the hospice admissions nurse to the facility staff indicated, "8pm give bedtime meds, including [redacted]

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 5 | A 035 | | |

[redacted]

6. The November 2012 Medication Administration Record (MAR) indicated the resident received [redacted] The MAR indicated, "Before you give [name of the resident] the [redacted] contact the nurse first before giving the medication." The MAR indicated the resident received the [redacted] on [redacted] /12 [redacted] Then on [redacted] /12 for breathing, and from [redacted] /12 through [redacted] /12. The MAR indicated the staff had been initialing that the medication had been given and administered to the resident by the employees at the facility.

7. A communication form dated 12/03/12 written by the facility Administrator to the staff indicated the administrator had been directing her staff to administer (not assist) the [redacted] by indicating, [name of R #1] "Can have [redacted] please contact the nurse before giving [redacted] the medication." A second communication form dated 12/12/12 written by the facility Administrator to the staff indicated, "When you give [name of R #1] a second [redacted] when you give the [redacted] one hour later if [redacted] is up and [redacted] give [redacted] the second [redacted] and record it...On [redacted] /12 [redacted] 12, "Gave [redacted]

8. Physician Orders dated [redacted] /12 indicated the following medications: [redacted]

9. The December 2012 MAR indicated the resident had received [redacted] 12 through [redacted] /12 which was being administered by the staff. It further indicated, [redacted]

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 6 | A 035 | | |

daily. Draw up the [redacted] up to the line [redacted] The MAR indicated that the resident received the [redacted] from [redacted]/12 up through [redacted]/12 until it was discontinued on [redacted]/12. The [redacted] was also being administered by the facility staff.

10. Physician Telephone Orders dated [redacted]/12 indicated, [redacted]

11. The December 2012 MAR indicated the resident received the 2 dropper fulls of [redacted] two times daily on [redacted]/12 and on [redacted]/12. This was also being administered by the facility staff. The MAR further indicated that the resident received [redacted] beginning on [redacted]/12 and it continued to be administered twice a day from [redacted]/12 through [redacted]/12 by the facility staff.

12. Physician Telephone orders dated 01/10/13 indicated, [redacted] The resident was now requiring the [redacted] to be administered every hour instead of every two hours by the staff.

13. Physician orders dated [redacted]13 indicated: [redacted]

14. The [redacted] 2013 MAR indicated the resident received the [redacted] from January 1, 2013 through January 15, 2013. It further indicated [redacted] also received the [redacted] 13 through [redacted]/13. Then on [redacted]/13 the resident began to receive the [redacted] /13 through [redacted]/13. The resident was also administered the [redacted] /13 Sublingually by the staff.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 7<br>15. Daily Log (no date) written by facility staff indicated, [redacted] It further indicated on 12/07/12, "I waited...to give [redacted] meds." It indicated on 12/08/12, "I gave [redacted] all [redacted] meds about 7:30 pm. The [redacted] really seemed to finally calm him down." It indicated on [redacted] /12, "She would like us to start giving [redacted] for [redacted] On [redacted] /12, "I gave [redacted] second sleeping pill and the pill was ineffective...On [redacted] /12, [redacted]<br>16. On 10/08/13 at 8:30 am, during interview the Administrator stated, "Everyone that does medications is certified to take a test and to pass medications. We do have [redacted] as well as the [redacted] The Hospice nurse will write the order, as we are to give it to the resident in the liquid form." The Administrator then indicated that her employees can put orders into the computer and they can pass medications and give it to the residents to take. She further indicated, "This would be both assisting and administering medications."<br>17. On 10/08/13 at 10:45 am, during interview, the Administrator stated, "Towards the end of [name of R #1's] life, it was [redacted] that [redacted] was needing more of. [redacted] was bed bound and by that time we were giving [redacted] comfort meds. The Hospice nurse would say to go ahead and give [redacted] She would tell us verbally over the phone to give it. It was [redacted] form that we were giving [redacted]<br>18. On 10/08/13 at 2:55 pm, during interview, Caregiver #1 stated, "At the end of [name of R #1's] life, we would have to physically put the meds in his mouth. [redacted] From instructions from the Hospice nurse, we were allowed to give it to [redacted] Sometimes with the liquid, we would have to put in [redacted] I don't think he knew much as far | A 035 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 8 | A 035 | | |

as what medications he was taking. With the people on Hospice, at the end of life is when we would be able to administer their medications to them. Some end of life Hospice people, we would have to give them their pills and their drops and we would have to do for them."

19. On 10/08/13 at 2:15 pm, during interview, the Administrator stated, "Once they called the nurse and got the ok, then my staff were then giving [redacted] the [redacted] With [name of R #1], [redacted] would not have been able to self administer [redacted] own medications. Anyone who can self administer their medications would have to have an order. We could give [redacted] pills but when [redacted] was not able to take them, we would put the drops under [redacted] tongue. We've always been able to administer the [redacted] since its under the tongue. When they are end of life and when it comes to that point to where they can no longer take their medications, we have been administering it to them because that is the way I was taught."

20. On 10/09/13 at 8:20 am, during interview, Caregiver #2 stated, "When [name of R #1] got put onto Hospice [redacted] wasn't able to take [redacted] own medications. We would crush them and put them in apple sauce and I would give them to [redacted] I would administer [redacted] medications in [redacted] mouth. The [redacted] was in liquid form that I recall. I would put it on the side of [redacted] cheek. [redacted] would do ok with that. I would put it in [redacted] mouth. It was either [redacted] every hour. We had to draw it up ourselves in the [redacted] We would draw it up and administer it ourselves. The Hospice nurse left us the orders so we would know how much to give [redacted] She would explain to us how to draw it up to [redacted] With our current Hospice people, for example with [name of R #2], we get the cup and tap the pills into [redacted] mouth and [redacted] will swallow them by [redacted] When [redacted] is

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 9 | A 035 | | |

not with it, [redacted] can't take [redacted] own medications. I have had to help the residents take their medications before in the past by putting the spoon in their mouths."

21. On 10/09/13 at 11:00 am, during interview Hospice Registered Nurse (RN) stated, "Up until the very end [redacted] [referring to R #1] wasn't able to administer [redacted] own medications [redacted] It was our understanding that we would be doing the instructing on the use of the [redacted] then the staff here would be administering it. The Hospice would be instructing the caregivers on how to give it. We would document its use to the staff. We write the order for the staff, and then we talk to whomever is going to be administering the medication. For example what the med is and how often it is to be given, and then to call us if there is problem. It would be given here by whom so ever is qualified to give the medicine. I would have assumed that the staff here was knowledgeable enough to know what the medication is for and how to give it."

22. On 10/09/13 at 11:30 am during interview Caregiver #2 stated, "The instructions come to us from Hospice, so I would be one of the staff who would draw up the [redacted] by myself, then I would slowly be administering it to [redacted] by putting the [redacted] on the side of the cheek. At that time from what I recall, I would have put the pills in the cup and place them in [redacted] then give [redacted] a cup of water to swallow them down."

B. Record review and interviews for R #2 indicated the following information:

1. R #2 was admitted to Hospice services on [redacted]/13 with diagnosis of [redacted]

2. Physician Orders dated [redacted]/13 indicated [redacted]

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 10 | A 035 | | |

[redacted]

3. The Narcotic Record dated 10/20/13 indicated [redacted] was given on 10/01/13 [redacted] and was administered by staff at the facility. It was also administered to the resident on 10/03/13 [redacted] by the staff as well as on 10/04/13.

4. On 10/09/13 at 12:50 pm, during interview, the Administrator stated, [redacted] [referring to R #2] can be delusional at times, and [redacted] can be forgetful at times."

5. On 10/09/13 at 12:55 pm, during interview, Caregiver #2 stated, "With the [redacted] we have to draw it up in the [redacted] and we push it in [redacted] cheek on the side of the cheek and [redacted] will swallow it. I usually draw it up in the [redacted] myself and put it on the inside of [redacted]

6. On 10/09/13 at 1:15 pm during interview, Caregiver #3 stated, "In the past we would just give the [redacted] to the residents. We had one resident a couple of days before [redacted] we were having to give the [redacted] We would place it under [redacted]

C. Record review and interviews for R #3 indicated the following information:

1. R #3 was admitted to Hospice services on [redacted]/12 with a primary diagnosis of [redacted]

2. Physician orders dated [redacted]/12 indicated [redacted] Also [redacted] give [redacted]

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD LIFE SENIOR LIVING AND MEMORY CARE** | **1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 11 [redacted] | A 035 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2116 | A. BUILDING: _____ B. WING _____ | C 10/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD LIFE SENIOR LIVING AND MEMORY CARE | 1650 NORTH LOS LENTES RD NE LOS LUNAS, NM 87031 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 035 | Continued From page 12<br>having pain during re-positioning so [redacted] the Hospice nurse visited in the morning and stated [redacted] lungs did not sound good and that [redacted] breathing has changed. Also on 09/07/13, resident not doing well, Caregiver #1 has been "giving" the [redacted] every two hours. On 09/08/13 resident continues to decline through the night and staff "gave" [redacted]<br>D. Review of the facility's Caregiver Responsibilities job description (no date) indicated, "Assist resident with medication as scheduled."<br><br>E. Review of the facility's "Resident Medication Policy" (no date) indicated, "[name of the facility]...supervises the administration, self-administration of medications for residents..." It further indicated, "[name of facility] will assume responsibility for...assisting the resident at the proper time including PRN and temporary medications." | A 035 | | |