

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
NAME OF PROVIDER OR SUPPLIER GOOD LIFE SENIOR LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CHERRY LANE CARLSBAD, NM 88220		
(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 An initial survey was completed on 05/12/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the survey.	A 000		
A 008	7 NMAC 8.2.8 General Licensing Requirements GENERAL LICENSING REQUIREMENTS: A. Licensure is required. No person or entity shall establish, maintain or operate an assisted living facility without first obtaining a license. B. Application for licensure. An initial or renewal application shall be made on the forms prescribed by and available from the licensing authority. The issuance of an application form is not a guarantee that the completed application will be accepted, or that the department will issue a license. Information provided by the facility and used by the licensing authority for the licensing process shall be accurate and truthful. The licensing authority will not issue a new license if the applicant has had a health facility license revoked or renewal denied or has surrendered a license under threat of revocation or denial of renewal. The licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of applicable rules found to be class A or class B deficiencies as defined in Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC or has been non-compliant with plans of correction. The licensing authority will not issue a license until the applicant has supplied all of the information that is required by this rule. Any facility that fails to participate in good faith by falsifying information presented in the licensing process shall be denied licensure by the department. The following information shall be submitted to the licensing authority for approval:	A 008		

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 008	Continued From page 1 (1) a letter of intent that includes the proposed physical address, the primary population of the facility and a summary of the proposed services; after the letter of intent has been received, an application packet including; the application form, fee schedule and the licensing rule will be issued to the applicant by the licensing authority; (2) the completed and notarized application and the appropriate non-refundable fee(s); (3) a program narrative identifying and detailing the geographic service area, the primary population including any special needs requirements, along with a full description of the services that the applicant proposes to provide including: (a) a description of the characteristics of the proposed population of the facility; (b) a description of the services and care that will be provided to the residents; (c) a description of the anticipated professional services to be offered to the residents; and (d) a description of the facility ' s relationship to other services and related programs in the service area and how the applicant will collaborate with them to achieve a system of care for the residents. (4) policies and procedures annotated to this rule; (5) evidence to establish that the applicant has sufficient financial assets to permit operation of the facility for a period of six (6) months; the evidence shall include a credit report from one of the three recognized credit bureaus with a minimum credit score of six-hundred fifty (650) or above; (6) copies of organizational documents to include the following list of items: (a) the names of all persons or business entities that have at least five percent (5%) ownership interest in the facility, whether direct or indirect	A 008		

Division of Health Improvement

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A 008	Continued From page 2 and whether in profits, land or building; this includes the owners of any business entity which owns all or part of the land or building; (b) the identities of all creditors that hold a security interest in the premises, whether land or building; (c) any changes in ownership or management shall be reported to the department within thirty (30) days; (7) building plans as required at 7.8.2.41 NMAC of this rule; (8) fire authority approval as required at 7.8.2.60 NMAC of this rule; (9) a letter of approval or exemption from the local health authority having jurisdiction for the food service and the kitchen facility; (10) a copy of liquid waste disposal and treatment system permit from local health authority having jurisdiction; (11) approval from local zoning authority; (12) building approval (certificate of occupancy); and (13) any other information that the applicant wishes to provide or that the licensing authority may request. C. Application for amended license. A licensee shall submit an application for an amended license and the required non-refundable fee to the licensing authority prior to a change with the facility. An amended license is required for a change of: location, administrator, facility name, capacity or any modification or addition to the building. (1) An application for a change of the facility administrator or change of the administrator ' s name shall be submitted to the licensing authority within ten (10) business days of the change. (2) An application for increase in capacity shall be accompanied by a building plan pursuant to	A 008		

Division of Health Improvement

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A 008	Continued From page 3 7.8.2.41 NMAC of this rule. A facility shall not increase census until the licensing authority has reviewed and approved the increase and has issued a new license that reflects the approved increase in capacity. D. Application for license renewal. Each facility shall apply for a renewal of the annual license within thirty (30) business days prior to the license expiration date by submitting the following items: (1) an application and the required fee; (2) an updated program narrative, if the facility has changed the program or the focus of services; (3) the annual fire inspection report; and (4) the licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of this rule or has been noncompliant with plans of correction or payment of civil monetary penalties. E. License. Any person or entity that establishes, maintains or operates an assisted living facility shall obtain a license as required in this rule before accepting residents for care or providing services. (1) Each facility that provides care or treatment shall obtain a separate license. The license is non-transferable and is only valid for the facility to which it is originally issued and for the owner or operator to whom it is issued. It shall not be sold, reassigned or transferred. (2) The maximum capacity specified on the license shall not be exceeded. (3) If the facility is closed and the residents are removed from the facility, the license shall be returned to the licensing authority. Written notification shall be issued to all residents or the residents' surrogate decision maker and the licensing authority at least thirty (30) calendar days prior to the closure.	A 008		

Division of Health Improvement

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A 008	Continued From page 4 F. Temporary license. (1) A temporary license may be issued to a new facility before residents are admitted provided that the facility has met all of the life safety code requirements as stated in this rule and policies and procedures for the facility have been reviewed and approved. (2) Upon receipt of a temporary license, the facility may begin to admit up to three (3) residents. (3) After the facility has admitted up to three (3) residents, the facility operator or owner shall request an initial health survey from the licensing authority. (4) Following a determination of compliance with this rule by the licensing authority, an annual license will be issued. The renewal date of the annual license is based on the initial date of the first temporary license. (5) The licensing authority has the right to determine compliance or noncompliance. (6) A temporary license shall cover a period of time, not to exceed one hundred twenty (120) calendar days. (7) No more than two (2) consecutive temporary licenses shall be issued. If a second temporary license is issued, an additional non-refundable fee is required. If all requirements are not met within the two hundred forty (240) day time frame, the applicant shall repeat the application process. G. Annual license. An annual license is issued for one (1) year for a facility that has met all the requirements of this rule. H. Display of license. The facility shall display the license in a conspicuous public place that is visible to residents, staff and visitors. I. Unlicensed facilities. Any person or entity that opens or maintains an assisted living facility without a license is subject to the imposition of	A 008		

Division of Health Improvement

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A 008	Continued From page 5 civil monetary penalties by the licensing authority. Failure to comply with the licensure requirements of this rule within ten (10) days of notice by the licensing authority may result in the following penalties pursuant to Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC. (1) A civil monetary penalty not to exceed five-thousand dollars (\$5,000) per day. (2) A base civil monetary penalty, plus a per-day civil monetary penalty, plus the doubling of penalties as applicable, that continues until the facility is in compliance with the licensing requirements in this rule. (3) A cease and desist order to discontinue operation of a facility that is operating without a license. (4) Additional criminal penalties may apply and shall be imposed as necessary. [7.8.2.8 NMAC - Rp, 7.8.2.8 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.8 C. Based on record review and interview, the facility failed to: 1. apply for an amended license prior to or within 10 business days of changing Administrators; and 2. apply for another temporary license when the temporary license expired, and therefore were operating the facility unlicensed. This deficient practice could lead to the facility not having a qualified person providing oversight of the care of all the facility's 12 (R #s 1 through 12) residents as identified by the resident census list provided by the Administrator on 05/10/16. The findings are: A. Record review of facility records revealed the	A 008		

Division of Health Improvement

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A 008	Continued From page 6 following: 1. The Current Administrator was hired on 05/21/15. 2. The facility license had expired on 02/04/16. 3. There was no record of an application for a license renewal or change of Administrator. 4. The Termination Checklist for the previous Administrator had a termination date of 11/21/15. B. Record review of the expired facility license (expired 02/04/16) revealed it listed the previous Administrator as the current Administrator. C. On 05/11/16 at 8:38 am, during interview with the Administrator, she acknowledged the previous Administrator listed on the facility license had left the facility as Administrator in March of 2015 and the license expired on 02/04/16.	A 008		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents;	A 016		

Division of Health Improvement

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A 016	Continued From page 7 (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the	A 016		

Division of Health Improvement

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A 016	Continued From page 8 requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.16 B. (3 & 6) Based on record review and interview, the facility failed to ensure that 2 (DCS #s 2 & 3) of 4 (DCS #s 1-4) Direct Care Staff met the requirements for the following: 1. Employee Abuse Registry (EAR) inquiry prior to date of hire; 2. Caregiver Criminal History Screening (CCHS) for staff reviewed for CCHS. This deficient practice has the potential to affect all 12 (R #s 1 through 12) residents as identified by the resident census list provided by the Administrator on 05/10/16 by allowing a person who has been convicted of a felony or who has been placed on the EAR for Abuse, Neglect, and/or exploitation of an adult to have access to all residents. The findings are: A. Record review of DCS #2's staff records revealed a date of rehire as 03/21/16 and there was no inquiry made to EAR when the employee was rehired.	A 016		

Division of Health Improvement

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A 016	Continued From page 9 B. Record review of DCS # 2's & DCS #3's staff records revealed they did not meet the requirements for CCHS for the following: 1. DCS #2's date of rehire was 03/21/16, however, the application was sent to CCHS on 10/04/15 and closed on 10/27/15 with no clearance letter issued and there was no other evidence DCS #2 was ever cleared to work; 2. DCS #3's original date of hire was 10/17/14 and fingerprints were not done until 03/15/15 for CCHS which is required to be completed and sent to CCHS within 20 days of hire. C. On 05/12/16 at 2:15 pm, during interview, the Administrator confirmed that DCS #s 2 and 3 did not have proof of inquiry to EAR or clearance from CCHS for DCS #2 and DCS #3 did not meet the requirements of sending the required information to CCHS within the 20 days of date of hire.	A 016		
A 017	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	A 017		

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A 017	Continued From page 10 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 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: Refer to 7.8.2.17 C. Based on record review and interview the facility failed to ensure that 4 (DCS #s 1-4) of 4 (DCS #s 1-4) Direct Care Staff received training in the following required subjects: 1. fire safety and evacuation; 2. first aid; 3. safe food handling; 4. confidentiality;	A 017		

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A017	Continued From page 11 5. infection control; 6. resident rights; 7. incident reporting; 8. smoking policy; 9. quality care; 10. emergency procedures; 11. Individual Service Plan (ISP) implementation; and 12. Orientation/Training with 16 hours supervised prior to unsupervised care of residents. This deficient practice increases the potential to negatively impact the health, safety, and welfare of all residents by staff not knowing the proper methods of providing care and protecting residents from illness, injury or harm. The findings are: A. Record review of staff records for DCS #1 revealed a hire date of 06/18/15 and there was no documentation of training for the following: 1. fire safety and evacuation; 2. first aid; 3. safe food handling; 4. infection control; 5. resident rights; 6. incident reporting; 7. smoking policy; 8. quality care; 9. emergency procedures; 10. Individual Service Plan (ISP) implementation; and 11. Orientation/Training with 16 hours supervised prior to unsupervised care of residents. B. Record review of staff records for DCS #2 revealed only a rehire date of 03/21/16 and there was no documentation of training for the following: 1. fire safety and evacuation; 2. first aid;	A017		

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A 017	Continued From page 12 3. safe food handling; 4. infection control; 5. resident rights; 6. smoking policy; 7. quality care; and 8. emergency procedures. C. Record review of staff records for DCS #3 with a hire date of 10/17/14 and there was no documentation of training for the following: 1. fire safety and evacuation; 2. first aid; 3. safe food handling; 4. confidentiality; 5. infection control; 6. resident rights; 7. incident reporting; 8. smoking policy; 9. emergency procedures; and 10. Individual Service Plan (ISP) implementation. D. Record review of staff records for DCS #4 revealed a hire date of 02/26/16 and there was no documentation of training for the following: 1. fire safety and evacuation; 2. first aid; 3. safe food handling; 4. confidentiality; 5. infection control; 6. resident rights; 7. smoking policy; 8. quality care; 9. emergency procedures; and 10. Individual Service Plan (ISP) implementation. E. On 05/12/16 at 2:30 pm, during interview, the Administrator acknowledged the training for staff was not completed as required.	A 017		

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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 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	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 020	Continued From page 14 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; (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;	A 020		

Division of Health Improvement

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A 020	Continued From page 15 (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) 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	A 020		

Division of Health Improvement

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A 020	Continued From page 16 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] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.20 A. D. (1) Based on record review and interview, the facility failed to ensure that 3 (R #s 1 - 3) of 3 (R #s 1 - 3) residents whose records were reviewed for	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 020	Continued From page 17 completeness had the following: 1. the admission agreement dated prior to the admission date of the resident; 2. the admission agreement signed by the responsible party or the resident; 3. the program narrative dated when the responsible party received it; and 4. documentation of Coordination of Care for residents receiving medical services from a Home Health Agency. This deficient practice could likely result in a delay in care or harm to the residents if documents or important information is missing from the residents' records. The findings are: A. Record review of the chart for R #1 with an admission date of 08/10/15 revealed the following: 1. an admission agreement that was signed by the Power of Attorney (POA) and dated 09/08/15, which is 29 days after admission; 2. a program narrative signed by the Power of Attorney (POA) with no date of when it was received and signed by the POA; 3. an assistance with medication administration permission signed by the POA on 09/08/15; and 4. the resident was receiving medical services from a Home Health agency and there was no documentation of Coordination of Care with the Home Health agency and the facility. B. Record review of the chart for R #2 revealed an admissions agreement that was not signed by the POA, a family member, or the resident. C. Record review of the chart for R #3 revealed the resident was receiving medical services from a Home Health agency and there was no documentation of Coordination of Care with the	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 020	Continued From page 18 Home Health agency and the facility. D. On 05/12/16 at 2:30 pm, during interview, the Administrator acknowledged the following for R #1: 1. R #1 had an admission date of [REDACTED] 15; 2. The admission agreement was signed by the Power of Attorney (POA) and dated [REDACTED]/15, which is 29 days after admission; 3. The program narrative signed by the POA had no date of when it was received and signed by the POA; 4. The assistance with medication administration permission was not signed by the POA until 09/08/15; and 5. The resident was receiving medical services from a Home Health agency and there was no documentation of Coordination of Care with the Home Health agency and the facility. E. On 05/12/16 at 2:45 pm, during interview, the Administrator acknowledged the admissions agreement for R #2 was not signed by the POA, a family member, or the resident. F. On 05/12/16 at 2:50 pm, during interview, the Administrator acknowledged the Home Health Agency for R #3 were not providing documentation or information of the services for the resident to the facility.	A 020		
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	A 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 021	Continued From page 19 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; (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	A 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 021	Continued From page 20 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; (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,	A 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 021	Continued From page 21 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] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.21 A. (5) (d) Based on record review and interview the facility failed to ensure that 3 (R #s 1 - 3) of 3 (R #s 1 - 3) residents whose records were reviewed had a recent photograph. This deficient practice has the potential for Search and Rescue Personnel to be impeded and/or unable to find a resident should a resident disappear from the facility. The findings are: A. Record review of the facility's records	A 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 021	Continued From page 22 revealed no photographs for R #1, R #2 and R #3 in the records at the facility. B. On 05/12/16 at 2:30 pm, during interview, the Administrator acknowledged there were no photographs of R #s 1, 2, & 3 in the facility records.	A 021		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being;	A 025		

Division of Health Improvement

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A 025	Continued From page 23 (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.25 A. Based on record review and interview the facility failed to ensure 1 (R #1) of 1 (R #1) resident whose record was reviewed for accuracy had been evaluated prior to moving into the facility.	A 025		

Division of Health Improvement

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A 025	Continued From page 24 This deficient practice could lead to a resident being admitted that requires a higher level of care than the facility can provide or is allowed to provide which could affect the health and safety of the resident. The findings are: A. Record review of the chart for R #1 revealed the resident was admitted on [REDACTED]/15 and the resident's admission evaluation was not completed until 10 days later on [REDACTED]/15. B. On 05/12/16 at 2:30 pm, during interview, the Administrator acknowledged the admission's evaluation for R #1 was not done prior to admission of the resident.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation;	A 026		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 026	Continued From page 25 (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.26 A. (1) Based on record review and interview the facility failed to ensure that the resident Individual Service Plan (ISP) had details of services provided by another healthcare provider agency for 2 (R #s 1 & 3) of 2 (R #s 1 & 3) residents identified as receiving Home Health services. This deficient practice has the potential for the residents to not receive the appropriate care and assistance they need and the possibility of duplication of services or omission of needed services due to staff not knowing what services are being provided by the other agency. The findings are: A. Record review of the ISPs for R #1 & R #3	A 026		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/12/2016
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A 026	Continued From page 26 revealed no documentation of the services being provided by a Home Health provider. B. On 05/12/16 at 2:30 pm, during interview, the Administrator confirmed the Home Health Agency was providing services for R #1 & R #3 and there was no information on the ISP for those services.	A 026			
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The 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	A 034			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
NAME OF PROVIDER OR SUPPLIER GOOD LIFE SENIOR LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CHERRY LANE CARLSBAD, NM 88220		
(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 034	Continued From page 27 medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II 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	A 034		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 034	Continued From page 28 the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases 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: Refer to 7.8.2.34 A. (7) NFPA 99/1999 4-3.5.2.2 Storage of Cylinders and Containers Level I a) Facility authorities, in consultation with medical staff and other trained personnel, shall provide	A 034		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
NAME OF PROVIDER OR SUPPLIER GOOD LIFE SENIOR LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CHERRY LANE CARLSBAD, NM 88220		
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A 034	Continued From page 29 and enforce regulations for the storage and handling of cylinders and containers of oxygen in storage rooms of approved construction, and for the safe handling of these agents in anestizing locations. In storage locations, cylinders shall be properly secured in racks or adequately fastened in the upright position. b) Non Flammable Gases 1. Storage shall be planned so that cylinders can be used in the order in which they are received. 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. 3. Cylinders stored in the open shall be protected against extremes of weather and from the ground beneath to prevent rusting. During winter, cylinders stored in the open shall be protected against accumulations of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure to direct rays of the sun in those locations where extreme temperatures prevail. Based on observation and interview, the facility failed to store oxygen cylinders properly in a rack and failed to store them in a ventilated storage area. In the event of a fire or a cylinder being knocked over, oxygen cylinders may act like a missile with the potential to harm all 12 (R#s 1 through 12) residents as identified by the resident census list provided by the Administrator on 05/10/16 and all occupants of the building. The findings are: A. On 05/10/16 at 7:57 am, during a tour of the facility, the following was observed in the medication room:	A 034		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
NAME OF PROVIDER OR SUPPLIER GOOD LIFE SENIOR LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CHERRY LANE CARLSBAD, NM 88220		
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A 034	Continued From page 30 1. one 24 cubic foot (680 liter) oxygen cylinder not stored in a rack and completely unsecured; 2. one 24 cubic foot oxygen cylinder in a mobile rack for usage; 3. four 164 liter oxygen cylinders in a rack; 4. one liquid oxygen container for refilling tanks; and 5. the room was not ventilated to outside air. B. On 05/10/16 at 7:57 am, during an interview, Direct Care Staff (DCS) define #3 confirmed there were two 24 cubic foot oxygen cylinders, one not in a rack and unsecured, four 164 liter oxygen bottles, and one liquid oxygen container for refilling tanks stored in the medication room.	A 034		
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. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 036	Continued From page 31 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; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 036	Continued From page 32 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, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 036	Continued From page 33 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. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 036	Continued From page 34 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. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 036	Continued From page 35 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: Refer to 7.8.2.36 F. Refer to National Fire and Protection Agency (NFPA) 96, " Standard for Ventilation Control and Fire Protection of Commercial Cooking Operation The fire protection system requires annual and semi-annual inspections.	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 036	Continued From page 36 The cooking exhaust system requires quarterly cleaning. This includes from the origin (filters and hood) the run (Duct from hood to exhaust) and the terminus (Exhaust fan). This shall be done by an authorized contractor who places a sticker on the end of the hood with the company name, date of cleaning and next scheduled date. The facility can do this themselves but, they have to clean not only the filters but the entire system from the origin, run and terminus and they SHALL document this, keeping records to be made available to the inspector. Based on observation, record review, and interview the facility failed to protect the health and safety of the facility's 12 (R #1 through R #12) residents by not having documentation that the cooking exhaust system had the following: 1. quarterly cleaning; 2. semi-annual inspections; and 3. annual inspections. This deficient practice could lead to a grease fire in the cooking exhaust system putting all residents and occupants of the building in danger. The findings are: A. On 05/10/16 at 8:30 am, during a tour of the facility, the kitchen cooking exhaust system was observed and there were no stickers on the hood to signify it had been cleaned or had any inspections. B. Record review of facility records revealed no evidence that the kitchen cooking exhaust system had been cleaned or had any inspections. C. On 05/12/16 at 2:30 pm, during an interview with the Administrator and her Assistant, they acknowledged there was no documentation that the kitchen cooking exhaust system had been	A 036		

Division of Health Improvement

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A 036	Continued From page 37 cleaned or had any inspections.	A 036		
A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core.	A 043		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 043	Continued From page 38 [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.43 A. (1) Based on observation and interview, the facility failed to have a one hour fire rated enclosure room for the facility's two Gas Fired Hot Water Heaters. This deficient practice presents a risk to all 12 (R#1-12) residents as identified by the resident census list provided by the Administrator on 05/10/16 and all occupants of the building from smoke and fire passing through a penetration in the ceiling from this hazardous area into the attic and spreading throughout the building in the event of a fire. The findings are: A. On 05/11/16 at 1:47 pm, during a tour of the facility, a rectangular metal opening into the attic from the Gas Fired Hot Water Heater room approximately 6 inches by 12 inches was observed. This retangular metal opening was supposed to be sealed with metal all the way through the roof of the building to outside air for combustion air for the Gas Fired Hot Water Heaters and not have any openings from this room to the attic. B. On 5/11/16 at 2:00 pm, during an interview, the head of maintenance acknowledged that there was an approximately 6 inches by 12 inches rectangular metal opening into the attic from the Gas Fired Hot Water Heater room.	A 043		
A 045	7 NMAC 8.2.45 Water	A 045		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 045	Continued From page 39 WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC. A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations. B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non-community water system as defined by the current New Mexico drinking water requirements. C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented from entering potable water systems by appropriate cross connection and backflow prevention devices. D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries. E. The hot water temperature that is accessible to residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury. [7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.45 E.	A 045		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
NAME OF PROVIDER OR SUPPLIER GOOD LIFE SENIOR LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CHERRY LANE CARLSBAD, NM 88220		
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A 045	Continued From page 40 Based on observation and interview, the facility failed to ensure the hot water accessible to the residents was not above 110° F. This deficient practice has the potential of causing harm to the facility's 12 (R #s 1-12) residents, as identified by the resident census list provided by the Administrator on 05/10/16. The findings are: A. On 05/11/16 at 10:30 am, during tour of the facility with Direct Care Staff (DCS) #5, the hot water temperature in the handi-cap bathroom used by the residents was observed to be 120° F by the facility's and the surveyor's thermometers. B. On 05/11/16 at 10:30 am, during an interview with DCS #5, he confirmed the hot water temperature in the handi-cap bathroom used by the residents was observed to be 120° F.	A 045		
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) 13	A 062		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 062	Continued From page 41 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 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. 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. Based on observation and interview, the facility failed to ensure the Automatic Fire Protection	A 062		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 062	Continued From page 42 (Sprinkler) System was inspected quarterly or annually. Not having inspections as required could result in the sprinkler system not working properly in the event of a fire which presents the risk of potential harm to all 12 (Residents 1 through 12) residents and all occupants of the building. The findings are: A. Record review of facility inspection records revealed the automatic fire sprinkler system had no inspection records for quarterly (every 3 months) or annually (every 12 months) as required. B. On 05/12/16 at 2:30 pm, during interview, the Administrator acknowledged the automatic fire sprinkler system had not been inspected quarterly and annually as required.	A 062		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) 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	A 063		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 063	Continued From page 43 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: Refer to 7.8.2.63 A. (3) Based on observation and interview, the facility failed to annually maintain all portable fire extinguishers 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. This has the potential to harm all 12 (R #s 1 through 12) residents as identified by the census list provided by the Administrator on 05/10/16 and all other occupants of the building. The findings are: A. On 05/11/16 at 10:30 am, during tour of the facility, it was observed all portable fire extinguishers had not been serviced or inspected since January 2015 by an authorized contractor and, not inspected monthly by staff. B. On 05/12/16 at 2:30 pm, during an interview with the Administrator, she confirmed the fire extinguishers had not been serviced annually by an authorized contractor and, not inspected monthly by staff.	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	A 065		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 065	Continued From page 44 drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use 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 conduct the following: 1. fire drills on each shift for each quarter for the past year; 2. monthly fire drills; 3. fire drills using the fire alarm; and 4. an evacuation during any of the drills. This failed practice may result in the staff not being prepared to carry out a safe evacuation of residents and notification of the fire department in the event of a fire. This has the potential to harm all 12 (R #s 1 through 12) residents as identified on resident list provided by the Administrator on 05/10/16 and all occupants of the building. The findings are:	A 065		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
NAME OF PROVIDER OR SUPPLIER GOOD LIFE SENIOR LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CHERRY LANE CARLSBAD, NM 88220		
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A 065	Continued From page 45 A. Review of the facility's only fire drill records revealed the following: 1. Dates and times of the fire drills for the last 12 months were 08/31/15 at 2:00 pm, 10/01/15 [time of day not legible], 12/18/15 at 11:10 am, and 01/30/16 at 3:20 pm; therefore there were only 4 fire drills for the last 12 months, there was one that the time of day was unknown, only 2 were on the 7:00 am to 3:00 pm shift, and only 1 was on the 3:00 pm to 11:00 pm shift, when there should be 1 each quarter (every 3 months) on each shift, which should be 4 total on each shift for a 12 month period. 2. Documentation that the fire alarm was used only once during one of these drills on 01/30/16; and 3. Documentation that no evacuation of the residents was done during these drills. B. On 05/12/16 at 2:30 pm, during interview, the Administrator confirmed that the fire drills were not completed monthly or during each shift quarterly, that the fire alarm had only been tested during one drill, and no evacuation of the residents was done during any of the drills.	A 065		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to "DEFINITIONS," 7.8.2.7 NMAC, the following definitions shall also apply. (1) "Hospice agency" means an organization,	A 068		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
NAME OF PROVIDER OR SUPPLIER GOOD LIFE SENIOR LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CHERRY LANE CARLSBAD, NM 88220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCES (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 068	Continued From page 46 company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and	A 068		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 068	Continued From page 47 includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized	A 068		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 068	Continued From page 48 to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions.	A 068		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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A 068	Continued From page 49 (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and	A 068		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2016
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(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 068	Continued From page 50 services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.68 B. (1 & 2) & D. (6) (b) Based on record review and interview, the facility failed to ensure that 4 (DCS #s 1-4) of 4 (DCS #s 1-4) direct care staff had the following: 1. a minimum of 6 hours annually training for staff of palliative/hospice care, including 1 hour specific to the hospice resident's ISP; 2. offer an ongoing employee psychological support program for end of life care issues; and 3. to have documentation of each Hospice visit for a resident (R #2). This deficient practice increases the potential to negatively impact the health, safety, and welfare of residents receiving hospice services by staff not knowing the proper methods of providing care to protect Hospice residents from illness, injury,	A 068		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/12/2016
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A 068	Continued From page 51 or harm and for facility staff to not be informed of changes in the condition of resident after Hospice staff's evaluations during visits. The findings are: A. Record review of staff records for DCS #1 had a hire date of 06/18/15 and there was no documentation of 6 hours of annual training of palliative/hospice care training, including 1 hour specific to the hospice resident's ISP; and there was no documentation of an ongoing employee psychological support program for end of life care issues. B. Record review of staff records for DCS #2 with a rehire date of 03/21/16, revealed the following: 1. Documentation of only 1 hour of training of palliative/hospice care training on 05/11/16 and no documentation of 1 hour specific to the hospice resident's ISP; and 2. No documentation of an ongoing employee psychological support program for end of life care issues. C. Record review of staff records for DCS #3 with a hire date of 06/25/15, revealed the following: 1. Documentation of only 4 hours of training of palliative/hospice care training and no documentation of 1 hour specific to the hospice resident's ISP; and 2. No documentation of an ongoing employee psychological support program for end of life care issues. D. Record review of staff records for DCS #4 with a hire date of 02/29/16, revealed the following: 1. Documentation of only 1 hour of training of palliative/hospice care training on 05/11/16 and	A 068			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/12/2016
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A 068	Continued From page 52 no documentation of 1 hour specific to the hospice resident's ISP; and 2. No documentation of an ongoing employee psychological support program for end of life care issues. E. Record review of facility records for R #2 revealed only 6 skilled nursing visit notes dated 03/10/16, 03/15/16, 03/22/16, 03/29/16, 04/06/16, and 04/07/16. There was no other Hospice documentation in the facility records for R #2. F. Record review of the Hospice agency's records for R #2 revealed the resident had been receiving Hospice services when admitted to the facility on 08/17/15 and continued to receive the services to date. G. On 05/12/16 at 2:30 pm, during interview, the Administrator confirmed the Hospice training for staff was not completed as required and the Hospice agency had not been leaving documentation for all their visits for R #2.	A 068			
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,	A 070			

Division of Health Improvement

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NAME OF PROVIDER OR SUPPLIER GOOD LIFE SENIOR LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CHERRY LANE CARLSBAD, NM 88220		
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A 070	Continued From page 53 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 by: Refer to 7.8.2.70 E. Employee Abuse Registry 7.1.12 NMAC Refer to 7.1.12. EMPLOYEE ABUSE REGISTRY ... 8 A. through F. 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an	A 070		

Division of Health Improvement

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A 070	Continued From page 54 employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The	A 070		

Division of Health Improvement

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A 070	Continued From page 55 department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] Refer to 7.8.2.70 D. Refer to 7.1.9.8 D-G. 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: ... D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the department of public	A 070		

Division of Health Improvement

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A 070	Continued From page 56 safety and the federal bureau of investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four (\$74) dollars. Of which, twenty-four (\$24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven (\$7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. ... E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The department and department of public safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico department of health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by department of public safety and the federal bureau of investigation that will fully and	A 070		

Division of Health Improvement

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A 070	Continued From page 57 completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility failed to ensure that 2 (DCS #s 2 & 3) of 4 (DCS #s 1-4) Direct Care Staff met the requirements for	A 070		

Division of Health Improvement

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A 070	Continued From page 58 the following: 1. Employee Abuse Registry (EAR) inquiry prior to date of hire; 2. Caregiver Criminal History Screening (CCHS) for staff reviewed for CCHS. This deficient practice has the potential to affect all 12 (R #s 1 through 12) residents as identified by the resident census list provided by the Administrator on 05/10/16 by allowing a person who has been convicted of a felony or who has been placed on the EAR for Abuse, Neglect, and/or exploitation of an adult to have access to all residents. The findings are: A. Record review of DCS #2's staff records revealed a date of rehire as 03/21/16 and there was no inquiry made to EAR when the employee was rehired. B. Record review of DCS #2's & DCS #3's staff records revealed they did not meet the requirements for CCHS for the following: 1. DCS #2's date of rehire was 03/21/16, however, the application was sent to CCHS on 10/04/15 and closed on 10/27/15 with no clearance letter issued and there was no other evidence DCS #2 was ever cleared to work; 2. DCS #3's original date of hire was 10/17/14 and fingerprints were not done until 03/15/15 for CCHS which is required to be completed and sent to CCHS within 20 days of hire. C. On 05/12/16 at 2:15 pm, during interview, the Administrator confirmed they did not have proof of inquiry to EAR or clearance from CCHS for DCS #2 and DCS #3 did not meet the requirements of sending the required information to CCHS within the 20 days of date of hire.	A 070		