STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: _____ B. W NG _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	800 JUAN ANDRES LANE LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 The following deficiencies were cited during a Complaint survey completed on 08/05/21 for the state requirements of 7 NMAC 8.2 Regulations for Assisted Living. Complaint #NM52261 was substantiated with deficiencies cited. Complaint #NM52258 was substantiated with deficiencies cited.	A 000		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include:	A 021		

Rita Grabler Administrator 10/08/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: _____ B. W NG _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	800 JUAN ANDRES LANE LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 021	Continued From page 1 (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 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	A 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: _____ B. W NG _____	C **08/05/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	**800 JUAN ANDRES LANE LOS LUNAS, NM 87031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 021	Continued From page 2 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, 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.	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: B. W NG _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	800 JUAN ANDRES LANE LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 021	Continued From page 3 [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 A (7) (8) Based on record review and interview, the facility failed to ensure for 1 (R #1) of 4 (R #s 1-4) residents whose resident records were reviewed for compliance and were maintained onsite for review by the Licensing Authority included: 1. Internal Incident Reports (written accounts of all accidents, injuries, illnesses or reports). 2. Direct Care Staff (DCS) notes. This deficient practice could likely result in the residents being at risk of harm or injury, if the facility is not completing and maintaining onsite and available for review Internal Incident Reports and DCS notes, and: 1. The DCS providing care and services to the residents are not aware of recent changes in care, services, treatments, medication, etc. that were made due to recent accidents, injuries, or illnesses that may have required emergency medical treatment. 2. There is no oversite by the Licensing Authority. The findings are: A. Record review of R #1's resident file revealed no documentation of the facility's internal/external incident reports or DCS notes to indicate that R #1 had [redacted] from the facility as reported in Intake #NM52261 dated [redacted]/21.	A 021	Immediately took action to ensure that incident reports and direct care staff notes for each resident are maintained in accordance with specific requirements and are readily available on site. Will in the future ensure that incident reports and direct care staff notes for each resident are maintained in accordance with specific requirements and are readily available on site. Will ensure that all staff complete incident reports and direct care staff notes for each resident and are maintained in accordance with specific requirements and are readily available on site. Administrator will monitor on a quarterly basis that records for each resident are well maintained in accordance with specific requirements listed above and are readily available on site. Corrective action is complete.	10/07/ 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: B. W NG _____	C 08/05/2021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 021	Continued From page 4 B. On 07/30/21 at 8:03 am, during an interview with maintenance staff, he revealed that in March 2021 (03/19/21), R #1 had [redacted] from the facility and the (maintenance staff) returned R #1 to the facility from outside. C. On 08/05/21 at 10:37 am, during an interview with a former Cook, he stated that he remembered the incident of R #1 walking toward the street by [redacted] in front of the facility. He could not remember exact date. He (the cook), stated that he requested the maintenance staff to bring [redacted] back to the facility. D. On 08/05/21 at 3:02 pm, during an interview with the Administrator, she confirmed that R # 1's resident files were not organized and lacked information regarding an incident where R #1 had [redacted] and had to be returned to the facility by the maintenance staff member. E. On 08/10/21 during an interview with R #1's Power of Attorney (POA), he confirmed that the incident was never reported to him. 7 NMAC 8.2.26 Individual Service Plan	A 021		
A 026	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	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: B. W NG _____	C **08/05/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	**800 JUAN ANDRES LANE** **LOS LUNAS, NM 87031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 026	Continued From page 5 practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 B (7) Based on record review and interview, the facility failed to ensure for 2 (R #s 1 & 2) of 4 (R #s 1-4) residents whose Individual Service Plans (ISPs) were reviewed for compliance: 1. Included goals and expected outcomes for	A 026	Immediately took action to ensure that ISP's are developed and implemented within 10 calendar days of admission and are reviewed and or revised every 6 months or when there is a significant change. Will in the future ensure that ISP's are developed and implemented within 10 calendar days of admission and are reviewed and or revised every 6 months or when there is a significant change. Will have the nurse ensure that ISP's are developed and implemented within 10 calendar days of admission and are reviewed and or revised every 6 months or when there is a significant change. Administrator and nurse will monitor monthly ensure that ISP's are developed and implemented within 10 calendar days of admission and are reviewed and or revised every 6 months or when there is a significant change. Corrective action is complete.	10/07/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: B. W NG _____	C 08/05/2021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 026	Continued From page 6 the care services listed on the ISP. 2. The ISPs were reviewed/updated at a minimum of every 6 months or when there is significant change in a resident's health status. This deficient practice could likely cause the residents to not achieve or maintain their highest level of mental and physical function if the Direct Care Staff (DCS) are not aware of what care and services they need to provide, if: : 1. There are no goals and expected outcomes listed on the ISPs. 2. The ISPs are not reviewed and updated a minimum of every 6 months or when a change of conditions occurs. The findings are: A. Record review of R #1's ISPs dated 11/04/20 and 04/09/21 revealed, there were no goals or outcomes listed on the ISPs. B. Record review of R # 2's chart revealed: 1. ISPs dated 02/12/20 and 04/20/21 revealed, there were no outcomes for the goals listed on the ISPs. 2. ISPs were not updated at a minimum of every 6 months or when a significant change in condition occurs. C. On 08/05/21 at 3:02 pm, during an interview with the Administrator, she confirmed that R #s 1 & 2 ISPs: 1. Were not being updated at a minimum of every 6 months or when a significant change in condition occurred. 2. ISPs for R #1 and R #2 were missing goals and outcomes.	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: B. W NG _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	800 JUAN ANDRES LANE LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 032	Continued From page 7	A 032		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1 & 2)	A 032		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: _____ B. W NG _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	800 JUAN ANDRES LANE LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 032	Continued From page 8 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview the facility failed to ensure for 2 (R #s 1 & 2) of 4 (R #s 1-4) residents whose resident records were reviewed	A 032	Immediately took action to ensure that all suspected cases or known incidents of resident abuse, neglect, or exploitation are reported in accordance with 7.1.13 NMAC. Will in the future ensure that all suspected cases or known incidents of resident abuse, neglect, or exploitation are reported in accordance with 7.1.13 NMAC. Will train all staff with knowledge of reporting suspected cases or known incidents or resident abuse, neglect, or exploitation in accordance with 7.1.13 NMAC. Administrator and nurse will monitor incident reports weekly that all suspected cases or known incidents of resident abuse, neglect, or exploitation are reported in accordance with 7.1.13 NMAC. Corrective action is complete.	10/07/2021

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: B. W NG _____	C 08/05/2021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 032	Continued From page 9 for compliance that incidents of unusual occurrence were reported to the Licensing Authority within 24-hours, or the next business day, if a holiday or a weekend. This deficient practice could likely result in the residents being at risk of harm, injury, or death if the facility is not reporting incidents of unusual incidents (elopement) and there is no oversite by the Licensing Authority The findings are: Findings related to Elopement: A. Record review of complaint intake NM52261 dated 06/07/21, revealed that resident #1 (R #1) had [redacted] from the facility on [redacted]/21, but there was no documentation that the incident was reported to the family or the Licensing Authority within 24 hours or the next business day if a weekend or holiday. B. On 07/30/21 at 8:03 am, during an interview with the maintenance staff, he confirmed that R #1 had [redacted] through the front door and was heading to the street when the former cook asked him to go get [redacted] back into the facility. C. On 08/05/21 at 10:37 am, during an interview with the former cook, he confirmed that R #1 had [redacted] through the front door while the DCS (Direct Support Staff)were busy helping other residents. He also confirmed that he was the one who noticed the resident walking outside the building heading to the street and called on the maintenance staff to get her back. D. On 08/05/21 at 3:02 pm, during an interview with the Administrator, she confirmed that R #1 (Memory Care resident) [redacted] from the facility on [redacted]/21 when [redacted] was brought over to the	A 032		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 032	Continued From page 10 main building (unsecured) to play bingo. She stated that R #1 left the building (unsecured) through the front door without anyone seeing [redacted] The Administrator stated that R #1's [redacted] was relayed to her by the maintenance staff. In addition, the Administrator said that she was not aware that such an incident was to be reported to the family or Licensing Authority since the resident was not harmed. The Administrator also confirmed that she had misplaced/lost the folder containing internal incident reports requested by the surveyors. E. On 08/10/21 at 4:43 pm, during an interview with R #1's [redacted] and the Power of Attorney (POA) confirmed that [redacted] was never informed of the incident. Finding related to resident not being changed. F. Record review of the Internal Incident report dated 02/13/21 revealed that R #2 had been [redacted] was found [redacted] and beginning to [redacted] There was no documentation that the incident was reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. G. On 08/05/21 at 3:02 pm, during an interview with the Administrator, she stated that she did not recall any incident being reported to her, where R #2 had been [redacted] H. On 08/10/21 at 1:41 pm, during an interview with DCS #3, she confirmed that she came on duty in the afternoon at 2:00 pm on 02/13/21, and that she along with with DCS #4 found R #2 in [redacted] and beginning to [redacted]	A 032		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: _____ B. W NG _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	800 JUAN ANDRES LANE LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 032	Continued From page 11 [redacted] I. On 08/11/21 at 1:53 pm, during an interview with DCS #4, she confirmed that she and DCS #3 witnessed the incident above on 02/13/21 and that an internal incident report was written, but does not know if it was reported to the state.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program.	A 033		

PRINTED: 09/13/2021
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: B. W NG _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	800 JUAN ANDRES LANE LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 033	Continued From page 12 D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without	A 033		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: B. W NG _____	C **08/05/2021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 033	Continued From page 13 unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: B. W NG _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	800 JUAN ANDRES LANE LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 033	Continued From page 14 of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (1, 10-11 (a)) Based on record review, observation, and interview, the facility failed to ensure the following: 1. Facility was following the Covid-19 (a mild to severe respiratory illness that is caused by a novel corona virus which is thought to be transmitted person to person chiefly by contact with infectious material (such as respiratory droplets), and is characterized especially by fever, cough, shortness of breath that may progress to pneumonia and respiratory) screening (answer questions and and taking temperatures) process for visitors/staff entering the facility. 2. Residents were free from use of physical restraints. 3. Residents were checked on, cleaned, fed, and changed when wet. This deficient practice could likely result in the 12 (R #s 1-12) residents listed on the resident census provided by the Administrator on 07/28/21, to be at risk of harm if: a. Residents were exposed to and/or contracted the Covid-19 virus. b. Suffering physical injuries and/or mental harm by being restrained and not able to freely move around.	A 033	Immediately took action to ensure all staff understands, protects, and respects the rights of all residents. All visitors/staff entering the building will be screened for Covid-19 and will answer the questionnaire and take temperature. All residents will be free from physical restraint. Will in the future ensure all staff understands, protects, and respects the rights of all residents. All visitors/staff entering the building will be screened for Covid-19 and will answer the questionnaire and take temperature. All residents will be free from physical restraint. Will have all new staff members trained to understand, protect, and respect the rights of all residents. All visitors/staff entering the building will be screened for Covid-19 and will answer the questionnaire and take temperature. All residents will be free from physical restraint. Administrator will monitor daily that our facility understand, protects, and respects the rights of our residents. All visitors/staff entering the building will be screened for Covid-19 and will answer the questionnaire and take temperature. All residents will be free from physical restraint. Corrective action is complete.	10/07/2021

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: B. W NG _____	C **08/05/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	**800 JUAN ANDRES LANE** **LOS LUNAS, NM 87031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 033	Continued From page 15 c. Personal hygiene care, and food are not being provided and the resident becomes ill, develops skin problems such as blisters and bruises. The findings are: Findings related to Covid screening. A. On 07/28/21 at 7:35 am, during observation the Direct Care Staff (DCS) on shift at the facility failed to screen the surveyors upon on arrival for Covid-19 and failed to take their temperatures. B. On 07/28/21 at 10:00 am, during an interview with the Administrator, she stated that DCS have been taking temperatures and screening all visitors and staff. Records for screening were requested but not provided to the surveyors prior to the survey exit on 08/05/21. C. On 07/28/21 at 10:04 am, during an observation, DCS #1 took the surveyors temperatures and screened the surveyors for Covid-19. The Administrator confirmed that the screening and temperature recordings for surveyors had not been completed upon arrival into the facility on 07/28/21 at 7:35 am. Findings related to restraints D. On 07/28/21 at 3:31 pm, during observation of the common sitting room, R #2 was observed sitting in a [redacted] E. On 07/30/21 at 9:45 am, during an interview	A 033		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BUILDING: _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE MEMORY CARE	800 JUAN ANDRES LANE LOS LUNAS, NM 87031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 033	Continued From page 16 with R #2's Power of Attorney (POA [redacted], [redacted] confirmed that [redacted] had requested that [redacted] when not in bed was restrained in a [redacted] with a tray, that [redacted] had requested the staff members to do so to avoid falls. F. On 08/05/21, during an interview with the Administrator, she stated that she was not aware the tray placed on the [redacted] was being use as restraint; she stated that she believed they used the tray for the resident to have activities while [redacted] G. On 08/10/21 at 1:53 pm, during an interview with Direct Care Staff (DCS #4), she confirmed that R #2's [redacted] always asked staff to restrain [redacted] in the [redacted] with a tray to avoid falls even though staff would tell her it is not allowed by State Regulations. Findings related to changing resident. H. Record review of Internal Incident report dated 02/13/21 at 9:30 pm, revealed that R #2 [redacted] I. On 08/05/21 at 3:02 pm, during an interview with the Administrator, she informed surveyors that she was not aware of any incident where R #2 had been [redacted] J. On 08/09 21 at 11:40 am, during an interview with the hospice care nurse, she stated that she had heard of R #2 being [redacted] but that she never witnessed the incident	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2237	A. BU LDING: B. W NG _____	C 08/05/2021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY 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 033	Continued From page 17 and it was told as "Hearsay" around the facility so she did not write it down. K. On 08/10/21 at 1:41 pm, during an interview with a former DCS #3, she confirmed that she reported to work at 2:10 pm on 02/13/21 and that she and DCS #4 were told by DCS #s 1 and 5, that R #2 had not eaten, refused to get out of bed, or get changed. DCS #3 stated that she wrote an internal report, informed the (former manager), and called hospice because R #2's temperature was 102 degrees Fahrenheit (F). L. On 08/10/21 at 2:55 pm, during an interview with DCS #5 (former employee), she stated that she could not recall an exact date but remembered that periodically, R #2 would be [redacted] She informed me she could not recall or confirm the incident in February or March 2021, but could not say it did not happen. It was often that R #2 refused care and service and got aggressive with staff. I was unable to reach DCS #1 - made 3 attempts on 08/10/21 at 2:00 pm, at 3:00 pm, and on 08/11/21 at 11:00 am on the phone number at hand.	A 033		