Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An initial survey was completed on 07/11/16, for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the survey.	A 000	A008 7NMAC 8.2.8. General Licensing Requirements. 1. How violations will be corrected? Manager has been in contact with the DOH to request a copy of the temporary license. All fees have been paid. Awaiting the license to be delivered by mail. All residents are affected by this. 2. How will we monitor the corrective action and ongoing compliance ? Constant contact with representative of Department of Health to assure that all requirements are being met. Weekly follow up on all pending documentation regarding license. Reaching out to state surveyor for support and procedural advise. 3. Specify the date the corrective action will be completed. As of today, March 31, 2017, all correct documents have been submitted and submission was confirmed by the representative of DOH via email	
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 DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anna M. Sproule, C.O.O. TITLE (X6) DATE: 11 May 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 008	Continued From page 3	A 008		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ____ B. WING ____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ________ B. WING ________	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 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: 7.8.2.8 (H) Based on observation and interview, the facility failed ensure that the facility's temporary license was displayed in a conspicuous place where all 10 (R #s 1-10) residents currently residing in the facility, visitors, and staff can see it. If the facility license is not displayed then residents, visitors, and staff will not know if the facility has and is maintaining a current license as an Assisted Living Facility. The findings are: A. On 07/14/16, at 8:00 am, during observation the facility's temporary license was not posted in the facility. During an interview with the Administrator, she confirmed that the facility	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 008	Continued From page 6 license is not posted and does not know were it is.	A 008	A016 7NMAC 8.2.16 Staff Qualifications 1. How will it be corrected? All employees hired will be put through the EAR and CCHSP prior to them setting foot on the floor of the facility to work in the position they were hired for. All residents affected by this deficiency. 2. How will we monitor the corrective action and ongoing compliance? The manager and / or the assistant manager will run and EAR and CCHSP check on every employee using the New Mexico Background Check Tutorial at https://nmhealth.cchsp.com. We also have a directions on how to hire an employee for the manager and or assistant manager to follow printed and kept in a Background Check binder in the office. Each manage has a checklist of steps to follow for hiring employees. 3. Specify the date the corrective action will be completed. As of today, March 31, 2017 the employees hired have been put through the EAR and CCHSP prior to working at GoodLife. As of today, March 31, 2017 the tutorial and direction are being used by managers to be compliant.	
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; (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;	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ____ B. WING ____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 7 (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 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: 7.2.8.16 B (3) (6) (7)	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 8 Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 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 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,	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 9 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 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]	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ____ B. WING ____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 10	A 016		

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 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.

. . .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 11 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 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	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 12 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 3 (S #s 3, 4, and 5) of 4 (S #s 3-6) staff files reviewed for compliance failed to: 1. Meet the Employee Abuse Registry (EAR) Requirements. 2. Meet the Caregivers Criminal History Screening Program (CCHSP) Requirements. This deficient practice has the potential to affect all residents by allowing a person who has been placed on the registry and/or a criminal felon to have access to the residents. The findings are: A. Record review of S #3's (date of hire 12/09/15) Final Registry Report revealed that the EAR dated 02/08/16 inquiry was not submitted prior to hire and the CCHSP documentation was missing from the file.	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 016	Continued From page 13 B. Record review of S #4's (hire date 06/01/15) file revealed that the EAR inquiry dated 06/22/15 was not submitted prior to the hire and the CCHSP application dated 01/28/16 was not submitted within 20-days of hire. C. Record review of the of #5's (hire date 10/15/15) Final Registry Report revealed that the EAR inquiry was not submitted prior to hire and the CCHSP documentation was missing from the file. D. On 07/13/16 at 9:00 pm, during interview with the Administrator, she confirmed that the EAR inquiries for S #s 3, 4, and 5, were not made prior to hire as required and the CCHSP was not submitted within 20 days of hire.	A 016	**<u>A 017. 7NMAC 8.2.17</u>** **<u>Staff Training</u>** **1. How will it be corrected?** Each employee will receive the training required by the NMAC regulations prior to working a shift alone. We have Training documents each employee, manager, and trainer sign when the training is complete and during the training hours. All residents are adversely affected by this deficiency. **2. How will we monitor the corrective action and ongoing compliance?** The Manager has a NEW EMPLOYEE TRAINING DOCUMENT which documents the 16 hours supervised training or shadowing on the job training. The training also includes 12 hours of orientation according to the 12 topics to be taught both at the time of hire as well as annually. There are also the 4 hours for memory care training included in this as well. The manager has a GLSL NEW EMPLOYEE TRAINING CHECK LIST to be completed by the trainer and the new employee before e assuming any job responsibilities alone. The manager keeps these with and employee roster in the EMPLOYEE ORIENTATION BINDER to manage all documents efficiently. The manger also includes all MEDICATION ASSISTANCE Training into this binder. All training is up to date on all employees. **3. Specify the date that the corrective action will be completed:** As of 10 May, 2017 these systems are in place.	
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 involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling;	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 14 (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: 7.8.2.17 C (11) Based on record review and interview, the facility failed to ensure that training was completed 1 (S #7) of 1 (S #7) Staff who were reviewed for Assisting with Medication Delivery. This deficient practice increases the potential to negatively impact the health, safety, and welfare of all residents if staff do not know the proper methods of Assisting with medications. The finding are: A. Record review of S#7 employee file, revealed no documentation of Assisting with Medication	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 15 Delivery training. B. On 07/14/16 at 7:45 am, during observation S#7 was assisting with medication delivery. C. On 07/14/16 at 8:23 am, during interview with the administrator, she confirmed that S #7, had no documentation in her file of receiving the assisting with medication delivery training. The administrator stated that the staff have completed the course, but did not know how to print out the certificate.	A 017	**<u>A020 7NMAC 8.2.20</u>** **<u>Admissions and Discharge</u>** **1. How ill it be corrected?** The admission agreement must state 1) agreement may be terminated if appropriate placement is found 2)admission agreement must say the resident's stay my be terminated for non-payment with a 15 day written notice. 3) admission agreement narrative must state that the facility is operating as a memory care. The admission agreement has been changed to reflect these three changes. 2. **How will we monitor the corrective action and ongoing compliance?** The old admission agreement has been removed form the document repository. The new additions to the agreement have been added to the admission agreement. Manager is aware and educated of the changes. The current resident agreements were revised to include changes made to the Admission agreement. Going forward, all new residents will use the newly revised Admission agreement that was revised on March 31, 2017 and the old one was removed from our document repository. 3. **Specify the date the corrective action will be completed.** As of today 10 May 2017, the documents have been corrected to reflect the required changes.	
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	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 16 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 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	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 17	A 020		

(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;
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ____ B. WING ____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 18 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 complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (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	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ___ B. WING ___	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 19	A 020		

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:
7.8.2.20 A (2) (12) (a)

Based on record review and interview, the facility failed to ensure that for 2 (R #s 1 and 2) of 4 (R #s 1- 4) the Admission/Discharge Agreements included the following:

1. That the admissions agreement can be terminated by the facility "if" appropriate placement has been found for the resident.
2. 15-day written notice for non-payment of rent.
3. The facility is operating as a memory care unit.

This deficient practice has the potential for residents to be at risk of harm:

1. Being terminated without an appropriate placement for residents to be transferred to.
2. If the admissions agreement terminates without a 15-day written notice.
3. Not knowing residents are in a memory care unit.

The findings are:

A. Record review of R #1's, admissions/discharge agreement dated 01/12/16,

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 20 revealed the following: 1. The agreement does not state it may be terminated "if" an appropriate placement is found for the resident. 2. The agreement states that the resident can be terminated from the facility for non-payment of rent without a written or thirty (30) day notice. 3. The agreement does not state in the narrative that the facility is a memory care unit. B. Record review of R #2's, admissions/discharge agreement dated 3/26/16, revealed the following: 1. The agreement does not state it may be terminated "if" an appropriate placement is found for the resident. 2. The agreement states that the resident can be terminated from the facility for non-payment of rent without a written or thirty (30) day notice. 3. The agreement does not state in the narrative that the facility is a memory care unit. C. On 07/13/16, at 8:45 am, during an interview with the administrator, she confirmed that R #s 1 and 2's, admission agreements do not state it may be terminated "if" an appropriate placement is found, the admissions agreement does not state the resident can be terminated for non-payment of rent with a 15-day written notice and the admission agreement does not state the facility is operating as a memory care unit.	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	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 021	Continued From page 21 specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (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	A 021	A 021 NMAC 8.2.21 Resident Records 1. How will it be corrected? The resident files will have a copy of the admission agreement in them. The resident files will have a most recent photo. The resident files will have a copy of the latest physical examination in them. The files will have the physical examinations and nursing assessments to show a time frame of six months between the two examinations. All residents can be hurt by this deficiency. 2. How will we monitor the corrective action and ongoing compliance? The table of contents in the resident files has been added. All items in the resident files has been organized according to the table of contents to include all items required. The manager office is now a tidy space with all appropriate papers filed in the proper places. The manager and the RN maintain the resident files to ensure all documents are in the proper place and all assessments, physical examinations, ISP, admission agreements, and all other documents are included. A new face sheet template was created and is being used that includes resident photos. 3. Specify the date the corrective action will be completed. As of today 3/31/2017 all documents in the resident files are in order.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 021	Continued From page 22 contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (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	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ____ B. WING ____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 021	Continued From page 23 facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 A (1) (4) (5) (d) Based on record review and interview, the facility failed to ensure the residents records for 3 (R #s 1, 2, and 4) of 4 (R #s 1- 4) residents reviewed for complete and accurate information regarding: 1. Admissions agreement. 2. Physical examination report.	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 021	Continued From page 24 3. Picture. This deficient practice could 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. On 7/12/16, record review of R #2, chare revealed there were no photo of resident. B. On 7/12/16, record review of R #3, chart revealed the admission agreement was missing and there were no photo of resident. C. On 7/12/16, record review of R #4, chart revealed the admission agreement and an up-to-dated Physical examination report was missing. The last physical examination report was completed on 12/9/14, over 10 months before the admitted date of 10/30/15. D. On 7/13/16, at 8:45 am during an interview with the Administrator, she confirmed that 1. The admissions agreement was missing from R #s 3 and 4, files. 2. The latest physical examination report was missing from R #4. 3. A latest photo was missing from R #s 2 and 3.	A 021	A026 7NMAC 8.2.26 Individual Service Plan 1. How will it be corrected? The ISP will be completed by an RN since the home is operating as a memory care unit. The ISP will be done every six months or as the level of care changes and it is required more frequently as the regulations explain. The ISP will be dated and signed they the RN. 2. How will we monitor the corrective action and ongoing compliance? The RN and the manager have a list of ISP completion and renewal dates for each resident. The manager follows up with the RN on the ISP to ensure they are signed and dated and completed properly. Together the manager and the RN support one another in checking each others work as a system of checks and balances to ensure compliance. We are also adopting a new medical medication management software recently begun in Lovington that will help flag upcoming ISP and Care Plan changes and	
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.	A 026	due dates that will help automate the system. For now, a paper list and a buddy check system are in place to ensure compliance. 3. Specify the date the corrective action will be completed. As of today, 3/31/2017 all the ISP are compliant.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ____ B. WING ____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 026	Continued From page 25 (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; (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 A (2) (3)	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 026	Continued From page 26 Based on record review and interview, the facility failed to ensure that the Individual Service Plans (ISP) were current, accurate for 2 (R #s 3 and 4) of 4 (R #s 1-4) residents reviewed for ISP compliance. This deficient practice has the potential for the residents not to receive the appropriate care and assistance they need as changes in their health status occurs. The findings are: A. On 07/12/16, record review of R #3 ISP dated 04/20/16, revealed it was not signed or dated by a license practical nurse, registered nurse or a physician extender. B. On 07/12/16, record review of R #4 ISP dated 10/30/15, revealed it has not been reviewed or revised every six months. D. On 07/12/16, during interview with the Administrator, she confirmed that R #3 ISP dated 04/20/16, was not signed or dated by a license practical nurse, registered nurse or a physician extender. R #4 ISP dated 10/30/15, has not been reviewed or revised every six months.	A 026	A027 NMAC 8.2.27 Resident Activities 1. How will it be corrected? The activities calendar will be posted and followed. All residents are adversely affected by this deficiency. 2. How will we monitor corrective action and ongoing compliance? The activities calendar is no longer written on a white board by random caregivers. The activities calendar is now typed out and sent out with the Family Newsletter at the start of each month. It is also posted in the home. Caregivers are assigned activities on the calendar to do with the residents as part of their duties. The manager turns in these Activity Calendars and Family Newsletters to the C.O.O. and C.E.O. monthly. The activity calendar and list of residents who participated in the activities along with the Resident Council notes are kept in an ACTIVITIES BINDER. 3. Specify the date the corrective action will be completed. As of March 31, 2017 the activities calendar and the Activities Binder are being used and maintained.	
A 027	7 NMAC 8.2.27 Resident Activities RESIDENT ACTIVITIES: Each facility shall provide or make available recreational and social activities appropriate to the residents ' abilities that meet their psychosocial needs and are relevant to their social history; including a balance of cognitive, reminiscence, physical and social activities. The facility shall post the activities and encourage residents to participate. [7.8.2.27 NMAC - Rp, 7.8.2.28 NMAC, 01/15/2010]	A 027		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ________ B. WING ________	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 27 This REQUIREMENT is not met as evidenced by: 7.8.2.27 Based on observation and interview, the facility failed to have recreational or social activities posted for all 10 residents (R #1-10) residents identified on the census list provided by the Administrator on 07/12/16. This deficient practice could lead to anxiety, isolation, boredom, and depression for the residents. The findings are: A. On 07/12/15, at 9:15 am, during observation, it was noted that no Activities Calendar was posted in any of the common areas of the facility. B. On 07/12/15, at 9:05 am, during interview with the Administrator, she confirmed that there were no activities calendar posted in the facility.	A 027	A 034 NMAC 8.2.34 Custodial Drug Permits 1. How will it be corrected? a)The medication room refrigerator now has a lock b)The Oxygen is stored in racks in a ventilated closet with a sign outside the room that says "No Smoking, Oxygen in Use". Those same signs are posted outside the rooms of residents who use oxygen as well. c) The narcotics are counted every shift following procedure using the NARCOTIC COUNT LOG BOOK 2. How will we monitor corrective action an ongoing compliance? a and b) the entire staff is to ensure the refrigerator remains locked and the oxygen is stored properly. Education of staff, verbal reminders, and corrective action are all used to maintain compliance. c) The manager, RN, and consulting pharmacist work together to maintain compliance. Education of staff, verbal reminders and corrective action are used 3. Specify the date the action will be completed. a) medication refrigerator lock completed 7/20/2016 b) the oxygen storage and signs were corrected and completed on 07/20/2016 c) the Narcotic count done every shift using the Narcotic Count Log Book was completed as of today, 3/31/2017.	
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.	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 034	Continued From page 28 (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet 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;	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 034	Continued From page 29 (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including 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	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 034	Continued From page 30 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: 7.8.2.34 A (3) (7) B (2) Reference NFPA 99, 1999 Edition Section 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 034	Continued From page 31 fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7]. 6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. 7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)]. Reference NFPA 99, 1999 Edition Section 8-3.1.11.3 (Signs) Based on observation and interview, the facility failed to ensure that:	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 034	Continued From page 32 1. Medication fridge was locked. 2. Oxygen cylinder tanks were stored securely. 3. "Oxygen in Use" signs were posted outside the rooms for residents who use oxygen. 4. Narcotic count sheet was complete and accurate. This deficient practice has the potential for all 10 (R#s 1-10) residents listed on the census provided by the administrator on 07/12/16, to be at risk of harm and/or serious injuries if: 1. The residents to have access to the unsecured medications 2. Oxygen cylinder tanks were to fall over damaging the valve, causing it to depressurize 3. Flammable items are brought into the resident's room because there is no warning sign posted 4. Residents may not receive pain/or anitpsychotic medications as ordered. Findings related to medication refrigerator A. On 07/11/16, at 3:15 pm, during observation of the medication refrigerator did not have a lock on it. B. On 7/11/16., at 3:35 pm the administrator, she confirmed that the medication refrigerator did not have a lock on it. Findings related to oxygen C. On 07/12/16, at 8:35 am, during observation of R #s 4 room one (1) unsecured oxygen cylinder was observed in the living area and no "oxygen in use" sign posted on the outside of the room. D. On 07/12/16, at 8:43 am, Staff (S #1) she	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 034	Continued From page 33 confirmed that there is one (1) unsecured oxygen cylinder in the living area and no oxygen in use sign posted out side the room. E. On 07/12/16, at 9:00 am, during observation of R #s 1, three (3) unsecured oxygen cylinder in the entry way and no "oxygen in use" sign posted outside the room. F. On 07/12/16, at 10:30 am, during an interview with S #2, she confirmed that there were three (3) unsecured oxygen cylinders in the living area. Findings related to narcotic count. G. Record review of February, 2016, though to April 2016, narcotic count verification forms was incomplete and the last entry was dated 04/11/16. H. On 07/13/16, at 11:07 am, during an interview with the Administrator, she confirmed that the April 2016, narcotic count verification form was not completed and the last entry was dated 04/11/16.	A 034		
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment. (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of	A 037	A037 7 NMAC 8.2.37 Laundry Services 1. How will it be corrected? The linen closet will get a vent to prevent residents and staff to become ill from mold and bacteria in potentially contaminated linens. All residents can adversely be affected by this deficit. 2. How will we monitor the corrective action and ongoing compliance? The linen closet door had a vent added to allow for air flow. 3. Specify the date the corrective action will be completed. The vent to the linen closet door was added on 11/3/2016	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 037	Continued From page 34 infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (9)	A 037		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 037	Continued From page 35 Based on observation and interview, the facility failed to ensure that the linens are stored in a ventilated closet. This deficient practice has the potential for all 10 (R#s 1-10) residents as identified on the resident census provided by the Administrator on 07/12/16, to be at risk of becoming ill from mold and bacteria contaminated linens. The findings are: A. On 04/11/16, at 3:30 pm, during observation the hall closet where clean linens are stored, was not ventilated. B. On 04/11/16, at 3:35 pm, during interview with Administrator, she confirmed that the linen closet was not ventilated.	A 037	A 044 7NMAC 8.2.44 Heating, Air-Conditioning and Ventilation 1. How will it be corrected? The gas heating system documentation was not present that the system had been checked, tested, or maintained. The gas heating system will be checked by a local company to maintain compliance. All residents can be adversely affected by this deficit. 2. How will we monitor the corrective action and on going compliance? A local company was called out. The system was tested and checked. The manager has a Maintenance Binder where the inspection is documented. The manager will instruct her maintenance person to do all annual checks and tests where appropriate and call outside vendors to perform those checks and tests to maintain compliance. The manager must report to her supervisor of all monthly checks performed to help manage compliance. These documentations are kept in the Maintenance Binder 3. Specify the date the corrective action will be completed. It was completed 11/3/2016	
A 044	7 NMAC 8.2.44 Heating, Air-Conditioning and Ventilation HEATING, AIR-CONDITIONING AND VENTILATION: A. Heating, air-conditioning, piping, boilers and ventilation equipment shall be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities shall have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility shall provide a minimum temperature of seventy (70) degrees fahrenheit, measured at three (3) feet above the floor, in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device shall be used for heating the facility.	A 044		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 044	Continued From page 36	A 044		

Portable heating units shall not be used for heating the facility. All heating appliances shall be permanently anchored and kept away from flammables such as curtains, bedcovering, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or presents danger from electrical shock.
D. Fireplaces and open flame heating shall not be utilized in sleeping rooms.
E. Gas fired water heaters shall not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms.
F. The facility shall be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means.
G. All openings to the outside air used for ventilation shall be screened for the control of insects and rodents. Screen doors shall be equipped with self-closing devices.
H. The facility shall have a system for maintaining the residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard. Fans shall be provided with protective shields when there is a potential for contact by any individual.
[7.8.2.44 NMAC - Rp, 7.8.2.45 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.44 A

Based on record review and interview, the facility failed to ensure that the gas heating system was checked, tested, and maintained annually by qualified personnel. If the heating system is not tested and inspected annually by qualified personnel, then all 10 (R #s 1-10) residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 044	Continued From page 37 identified on the resident census, provided by the Administrator on 07/12/16, are at risk of illness or death if the furnace quits working during cold weather or has a gas/carbon monoxide leak. The findings are: A. Record review revealed that the annual inspection of the gas heating system by a licensed plumber or a qualified maintenance person was missing from the facility's files. B. On 07/14/16, at 8:23 am, during interview with the Administrator, she confirmed that there was not a heater inspection record on file in the facility and unsure when the heater was inspected.	A 044	A 045 7NMAC 8.2.45 Water 1. How will it be corrected? The water temperature logs were not present. All residents can be harmed by this deficit. The maintenance person has monthly log sheets to record the water temperatures. The maintenance person will record monthly water temperatures to maintain safety for residents and staff. 2. How will we monitor the corrective action and on going compliance? The manager will instruct her maintenance person to do all monthly water checks and log them in the monthly log sheets. The manager must report to her supervisor of all monthly checks performed to help manage compliance. These water temperature log sheets are kept in the Maintenance Binder 3. Specify the date the corrective action will be completed. It was completed 7/14/2016. The maintenance person used the water temperature log sheets to record temperatures.	
A 045	7 NMAC 8.2.45 Water 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	A 045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 045	Continued From page 38 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: 7.8.2.45 E Based on observation and interview, the facility failed to ensure that the hot water temperatures were maintained within the range of 95 degrees Fahrenheit (F) and 110 degrees F for all 10 (R #s 1-10) residents identified on the census provided by the Administrator on 07/12/16. This deficient practice has the potential for residents to be at risk of being burnt by hot water. The findings are: A. On 07/12/16, at 8:22 am, during observation of resident room #2, the hot water temperature in both the sink and shower was observed to be at 128 degrees F. B. On 07/12/16, at 8:26 pm, during observation of residents room #3, the hot water temperature in both the sink and shower was observed to be at 126 degrees F.	A 045		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 045	Continued From page 39 C. On 07/12/16, at 8:43 am, during observation of residents room #5, the hot water temperature in both the sink and shower was observed to be at 122 degrees F. D. On 07/12/16, at 8:46 am, during an interview with the administrator, she confirmed that the water temperatures in residents room #2, the hot water temperature in both the sink and shower was observed to be at 128 degrees F, residents room #3, the hot water temperature in both the sink and shower was observed to be at 126 degrees F, and residents room #5, the hot water temperature in both the sink and shower was observed to be at 122 degrees F.	A 045	A 048 7NMAC 8.2.48 Electrical System 1. How will it be corrected? The electrical outlets within 3 feet of a water supply must be GFI sockets. This deficit has the potential to harm all residents. The Ice Maker and Dishwasher will be plugged into a GFI socket. 2. How will we monitor the corrective action and on going compliance? The manager instructed the maintenance to make sure the GFI outlets were in proper working order and the Ice maker and Dishwasher were plugged into the GFI outlets. The manager must report to her supervisor of all maintenance issues of this type for support completing items to help manage compliance. 3. Specify the date the corrective action will be completed. It was completed 11/3/2016	
A 048	7 NMAC 8.2.48 Electrical System ELECTRICAL SYSTEM: A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility shall know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances shall be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords shall not be used. The use of a multi-socket united laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six (6) feet in length is permitted for the intended purpose and not as an extension cord. [7.8.2.48 NMAC - Rp, 7.8.2.49 NMAC, 01/15/2010]	A 048		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 048	Continued From page 40 This REQUIREMENT is not met as evidenced by: GFCI 7.8.2.48 Based on observation and interview, the facility failed to ensure electrical outlets within 3 feet of a water supply are Ground Fault Circuit Interrupters sockets. This deficient practice has the potential for all 10 residents (R #s 1-10) identified on the resident census, provided by the Administrator on 07/12/16, to be at risk of harm or death from electric shock. The findings are: A. On 07/13/16, at 9:55 am, during observation in the cabinet under the kitchen sink the dishwasher and ice machine were not plugged into GFCI outlets. B. On 07/13/16, at 10:07 am, the Administrator confirmed that the dishwasher and ice machine were not plugged into a GFCI outlet.	A 048		
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	A 063		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 063	Continued From page 41 extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Based on observation and interview the facility failed to ensure that 3 of 4 fire extinguishers had been inspected annually to ensure proper working order in case of fire. This deficient practice has the potential for all 10 (R #s 1-10) residents on the census list provided by the administrator on 07/12/16, to be at risk of harm if there is a fire and the fire extinguisher does not work properly. The findings are: A. On 07/12/16, at 9:15 am, during observation, the fire extinguisher next to the right back exit of the facility revealed that it had not been inspected since March 2015. B. On 07/12/16, at 9:20 am, during observation, the fire extinguisher next to the left back exit of the facility revealed that it had not been inspected since March 2015. C. On 07/12/16, at 9:22 am, during observation, the fire extinguisher opposite the Administrators office revealed that it had not been inspected since March 2015. D. On 07/12/16, at 10:39 am, during an interview with the administrator, she confirmed that the	A 063	A 063 7NMAC 8.2.63 Fire Extinguishers 1. How will it be corrected? The fire extinguisher checks documentation was not present that the extinguishers had been checked, tested, or maintained. The fire extinguishers will be checked by a local company to maintain compliance. This deficit is potentially harmful to all residents 2. How will we monitor the corrective action and on going compliance? A local company was called out. The extinguishers were checked. The manager has a Maintenance Binder where the inspection is documented. The manager will instruct her maintenance person to do all monthly checks on the extinguishers. The local company will come out to do yearly inspections and the facility maintenance will do the monthly checks to maintain compliance. These checks and reports are kept in the Manager's Maintenance Binder 3. Specify the date the corrective action will be completed. It was completed by the local company on 10/5/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ____ B. WING ____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

A 063 Continued From page 42 A 063

three (3) fire extinguishers were not inspected since March 2015.

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, 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.

<u>A068 7NMAC 8.2.68</u>

<u>Hospice</u>

1. How will it be corrected?

Prior to admission to hospice, a team meeting will be had for all residents who are put onto hospice. The ISP for hospice will be discussed and finalized at this meeting to coordinate care for the resident. The hospice ISP will be kept in the resident binder along with the facility ISP. The facility ISP will reference the Hospice ISP. The facility ISP will include documentation of the coordination of care.

2. **How will we monitor corrective action and ongoing compliance?**

A hospice team meeting including facility RN, administrator, and resident POA will be had prior to admission to determine needs of resident and finalize and ISP. The new ISP will be signed by appropriate petiole and filed in the resident file. The facility ISP will include documentation of the coordination of care. The is the procedure for all residents requiring hospice. RN and manager have been educated on procedure. Chart audits will help maintain compliance.

3. **Specify the date the corrective action will be completed.**

As of today, March 31, 2017 this is completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 068	Continued From page 43 (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 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	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ___ B. WING ___	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 068	Continued From page 44 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 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, "	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 068	Continued From page 45 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. (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	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**1706 N 2ND STREET LOVINGTON, NM 88260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 068	Continued From page 46 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 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: 7.8.2.68 C 2 (c)	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 068	Continued From page 47 Based on record review and interview, the facility failed to ensure for 1 (R #4) of 1 (R #4) resident identified as receiving hospice services to ensure that: 1. An Admission/Retention Exception team meeting was held prior to admission with hospice services. 2. The Individual Service Plan (ISP) reflects the coordination of care between the facility and the hospice provider. This deficient practice has the potential to affect the health and safety of the residents on hospice who require a higher level of care than the facility staff can provide. If there is no coordination of care documented in the ISP, then residents on hospice may not receive the increased level of care needed if staff do not know what care they need to provide and what care the hospice agency is providing. The findings are: A. Record review of R #4's resident file revealed no documentation that an admission/retention team meeting was held. B. Record review of R #4's ISP revealed no documentation of the care/services provided by the hospice agency. D. On 07/13/16, at 8:45 am, during interview with the Administrator, she confirmed that there was no team meeting held prior to accepting the hospice resident and no coordination of care on the ISP.	A 068		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 48 INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.2.8.70 D E Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 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	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 49 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 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	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 50	A 070		

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 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]

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 51 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 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	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 52 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 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	A 070		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ___ B. WING ___	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 53 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 3 (S #s 3, 4, and 5) of 4 (S #s 3-6) staff files reviewed for compliance by failing to: 1. Meet the Employee Abuse Registry (EAR) Requirements. 2. Meet the Caregivers Criminal History Screening Program (CCHSP) Requirements. This deficient practice has the potential to affect all 10 (R #s 1-10) residents identified on the census provided by the Administerator on 07/12/16, by allowing a person who has been placed on the registry and/or a criminal felon to have access to the residents. The findings are: A. Record review of S #3's (date of hire 12/09/15) Final Registry Report revealed that the EAR dated 02/08/16 inquiry was not submitted prior to hire and the CCHSP documentation was missing from the file. B. Record review of S #4's (hire date 06/01/15) file revealed that the EAR inquiry dated 06/22/15 was not submitted prior to the hire and the CCHSP application dated 01/28/16 was not submitted within 20-days of hire. C. Record review of the of #5's (hire date 10/15/15) Final Registry Report revealed that the EAR inquiry was not submitted prior to hire and the CCHSP documentation was missing from the	A 070	A070 7NMAC 8.2.70 Incorporated Related Rules and Codes 1. How will it be corrected? All employees hired will be put through the EAR and CCHSP prior to them setting foot on the floor of the facility to work in the position they were hired for. All residents affected by this deficiency. 2. How will we monitor the corrective action and ongoing compliance? The manager and / or the assistant manager will run and EAR and CCHSP check on every employee using the New Mexico Background Check Tutorial at https://nmhealth.cchsp.com. Manager has directions on how to hire an employee for the manager and or assistant manager to follow that are printed and kept in a Background Check binder in the office. Each manager has a checklist of steps to follow for hiring employees. This procedure is kept in the Manager's Background Check binder with all the documents for each employee. 3. Specify the date the corrective action will be completed. As of today, March 31, 2017 the employees hired have been put through the EAR and CCHSP prior to working at GoodLife. As of today, March 31, 2017 the tutorial and direction are being used by managers to be compliant.	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2290	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	1706 N 2ND STREET LOVINGTON, NM 88260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 54 file. D. On 07/13/16 at 9:00 pm, during interview with the Administrator, she confirmed that the EAR inquiries for S #s 3, 4, and 5, were not made prior to hire as required and the CCHSP was not submitted within 20 days of hire.	A 070		