STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 A complaint investigation for intake NM00029821 and an On-site/Monitoring survey were completed on 04/28/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the On-site/Monitoring survey. The Complaint was unsubstantiated with no deficiencies cited as a result of the complaint investigation.	A 000		
A 008	7 NMAC 8.2.8 General Licensing Requirements GENERAL LICENSING REQUIREMENTS: A. Licensure is required. No person or entity shall establish, maintain or operate an assisted living facility without first obtaining a license. B. Application for licensure. An initial or renewal application shall be made on the forms prescribed by and available from the licensing authority. The issuance of an application form is not a guarantee that the completed application will be accepted, or that the department will issue a license. Information provided by the facility and used by the licensing authority for the licensing process shall be accurate and truthful. The licensing authority will not issue a new license if the applicant has had a health facility license revoked or renewal denied or has surrendered a license under threat of revocation or denial of renewal. The licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of applicable rules found to be class A or class B deficiencies as defined in Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC or has been non-compliant with plans of correction. The licensing authority will not issue a license until the applicant has supplied all of the information that is required by this rule. Any facility that fails to	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ____ B. WING ____	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 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: (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;	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 (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 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	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 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 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	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

(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 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. 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	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 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 civil monetary penalties by the licensing authority. Failure to comply with the licensure requirements of this rule within ten (10) days of notice by the licensing authority may result in the following penalties pursuant to Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC. (1) A civil monetary penalty not to exceed five-thousand dollars ($5,000) per day. (2) A base civil monetary penalty, plus a per-day civil monetary penalty, plus the doubling of penalties as applicable, that continues until the facility is in compliance with the licensing requirements in this rule. (3) A cease and desist order to discontinue operation of a facility that is operating without a license. (4) Additional criminal penalties may apply and shall be imposed as necessary. [7.8.2.8 NMAC - Rp, 7.8.2.8 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.8 C. Based on record review and interview, the facility failed to apply for an amended license prior to or within 10 business days of changing Administrators. This deficient practice could lead to the facility not having a qualified person providing oversight of the care of all the facility's 12 (R #s 1 through 12) residents as identified by the resident census list provided by the Administrator on 04/26/16. The findings are:	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ____ B. WING ____	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 A. Record review of facility records revealed the Current Administrator was hired on 05/21/15. B. On 04/26/16 at 8:30 am, during interview with the Assistant Administrator, she acknowledged the previous Administrator listed on the facility license has been gone since March of 2015. C. Record review of the current facility license revealed it listed the previous Administrator as the current Administrator.	A 008		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (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	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.16 B. (3 & 6) Based on record review and interview, the facility failed to ensure that Direct Care Staff (DCS) met the Employee Abuse Registry requirements (EAR) for 5 (DCS #2, 4, 7, 9, & 11) of 11 (DCS #1 through #11) direct care staff files reviewed for EAR. This deficient practice has the potential to affect all residents by allowing a person who has been placed on the registry for abuse, neglect, and/or exploitation of an adult to have access to all residents. The findings are: A. Record review of 11 (DCS #1 through #11) direct care staff records revealed 5 (DCS #2, 4, 7, 9, & 11) inquiries to the Employee Abuse Registry were not done until after the date of hire for the following: 1. DCS #2 date of hire was 10/16/15 and inquiry was not done until 10/24/15; 2. DCS #4 date of hire was 08/04/15 and inquiry was not done until 08/08/15; 3. DCS #7 date of hire was 06/12/15 and inquiry was not done until 06/17/15; 4. DCS #9 date of hire was 09/29/15 and inquiry was not done until 10/04/15; and 5. DCS #11 date of hire was 09/09/15 and inquiry was not done until 10/04/15. B. On 04/07/16 at 2:15 pm, during interview, the Administrator confirmed DCS #2, 4, 7, 9, & 11 had not had inquiry to the registry prior to date of	A 016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 hire.	A 016		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs.	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 10	A 017		

D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation.
[7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
Refer to 7.8.2.17 C.
Based on record review and interview, the facility failed to ensure that 3 (DCS #s 1, 3 and 8) of 11 (DCS #s 1-11) Direct care staff (DCS) received training in the following required subjects:

1. fire safety and evacuation;
2. first aid;
3. safe food handling:
4. confidentiality;
5. infection control;
6. resident rights;
7. incident reporting;
8. smoking policy;
9. quality care;
10. emergency procedures; and
11. Individual Service Plan (ISP) implementation.

This deficient practice increases the potential to negatively impact the health, safety, and welfare of all residents by staff not knowing the proper methods of providing care and protecting residents from illness, injury, or harm. The findings are:
A. Record review of staff records for DCS #1 had a hire date of 01/26/16 and there was no documentation of training for the following:
1. incident reporting;
2. smoking policy;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ____ B. WING ____	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 11	A 017		

3. quality care training;
4. emergency procedures;
5. ISP Implementation training.

B. Record review of staff records for DCS #3 with a hire date of 06/19/15 and there was no documentation of training for the following:
1. fire safety and evacuation;
2. first aid;
3. safe food handling:
4. confidentiality;
5. infection control;
6. resident rights;
7. smoking policy;
8. quality care;
9. emergency procedures; and
10. Individual Service Plan (ISP) implementation.

D. Record review of staff records for DCS #8 with a hire date of 06/19/15 and there was no documentation of training for the following:
1. fire safety and evacuation;
2. first aid;
3. safe food handling:
4. infection control;
5. resident rights;
6. smoking policy;
7. quality care;
8. emergency procedures; and
9. Individual Service Plan (ISP) implementation.

E. On 04/28/16 at 2:30 pm, during interview, the Administrator acknowledged the training for staff was not completed as required for the facility staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 12	A 020		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination;	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ____ B. WING ____	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE** **CARLSBAD, NM 88220**

(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 13 (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints;	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ____ B. WING ____	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 15	A 020		

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 applicable, the referring party shall disclose any ownership interest in a recommended or listed provider.
[7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
Refer to 7.8.2.20 D. (1)

Based on record review and interview the facility failed to have documentation of Coordination of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 Care with outside agencies providing healthcare for 1 (R #2) of 2 (R #1 & 2) residents as identified by the resident census list provided by the Administrator on 04/26/16. This deficient practice could likely result in a delay in care or resident harm to the residents if documents or important information is missing from the residents records. The findings are: A. Record review of the chart for R #2 revealed the resident was receiving medical services from a Home Health agency and there was no documentation of the services the Home Health Agency was providing. B. On 04/28/16 at 2:30 pm, during interview, the Administrator acknowledged the Home Health Agency was not providing information to the facility for the services they are providing for R #2.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person 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;	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

(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 17 (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment 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	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

(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 18 for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, 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	A 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

(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 19	A 021		

from the resident records.
(3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request.
(4) There shall be a policy and procedure in place for record retention in the event of facility closure.
(5) Failure to follow facility policies is grounds for sanctions.
[7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
Refer to 7.8.2.21 A.

Based on record review and interview, the facility failed to ensure resident records contained a table of contents for 2 (R #S 1 & 2) of 2 (R #S 1 & 2) residents reviewed for complete an accurate records. This deficient practice could likely result in a delay in care or resident harm to the residents if documents or important information is missing from the residents records or the record is not kept in an organized manner. The findings are:

A. Record review of the chart for R #1 revealed there was no table of contents.

B. Record review of the chart for R #2 revealed there was no table of contents.

C. On 04/28/16 at 2:30 pm, during interview, the Administrator acknowledged there were no table of contents in the residents' charts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

(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	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (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.	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

(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 21 [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.26 A. (1) Based on record review and interview the facility failed to ensure that the resident Individual Service Plan (ISP) had details of services provided by another healthcare provider agency for 1 (R #2) of 2 (R #s 1 & 2) residents whose ISPs were reviewed for services provided by an outside agency. This deficient practice has the potential for the residents to not receive the appropriate care and assistance they need and the possibility of duplication of services due to staff not knowing what services are being provided by the other agency. The findings are: A. Record review of the ISP for R #2 revealed no documentation for the services being provided by a Home Health provider. B. On 04/27/16 at 11:00 am, during interview, the Administrator confirmed the Home Health Agency was not providing information to the facility for the services they were providing for R #2 and therefore, there was no information on the ISP for those services.	A 026		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

(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 22 the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription 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.	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 23 (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and 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	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 24 accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.34 A. (7) NFPA 99/1999 4-3.5.2.2 Storage of Cylinders and Containers Level I a) Facility authorities, in consultation with medical staff and other trained personnel, shall provide and enforce regulations for the storage and handling of cylinders and containers of oxygen in storage rooms of approved construction, and for the safe handling of these agents in anestizing locations. In storage locations, cylinders shall be properly secured in racks or adequately fastened in the upright position. b) Non Flammable Gases 1. Storage shall be planned so that cylinders can be used in the order in which they are received. 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE** **CARLSBAD, NM 88220**

(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 25	A 034		

hurriedly.
3. Cylinders stored in the open shall be protected against extremes of weather and from the ground beneath to prevent rusting.
During winter, cylinders stored in the open shall be protected against accumulations of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure to direct rays of the sun in those locations where extreme temperatures prevail.

Based on observation and interview, the facility failed to store oxygen cylinders properly in a rack and failed to store them in a ventilated storage area. In the event of a fire or a cylinder being knocked over, oxygen cylinders may act like a missile with the potential to harm all 12 (R#1 through 12) residents as identified on the resident census list provided by the Administrator on 04/26/16, and all occupants of the building. The findings are:

A. On 04/28/16 at 8:48 am, during a tour of the facility three 24 cubic foot oxygen cylinders were observed stored in the linen closet and one 24 cubic foot oxygen cylinder was stored in the Administrator's office. The cylinders were not secured in any kind of rack to keep them from falling over.

B. On 04/28/16 at 8:48 am, during an interview with the Administrator during the tour of the facility, she confirmed that three 24 cubic foot oxygen cylinders were stored in the linen closet and one 24 cubic foot oxygen cylinder was stored in the Administrator's office. She confirmed they were not secured in any kind of rack to keep them from falling over.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ____ B. WING ____	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE** **CARLSBAD, NM 88220**

(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 042	Continued From page 26	A 042		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the safety of the facility's 12 (R # 1 through 12) residents as identified by the resident census list provided by the Administrator on 04/26/16, by not maintaining the railing on the front porch of the facility in a sturdy state. This deficient practice has the potential for a resident using the railing for support to be in danger of falling. The findings are: A. On 04/28/16 at 9:30 am, during tour of the facility, the front porch railing was observed to have a support post broken loose at the base allowing the railing to move back and forth when touched. B. On 04/28/16 at 9:30 am, in an interview with	A 042		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 042	Continued From page 27 the Administrator during the tour of the facility, she confirmed the front porch railing had a support post broken loose at the base allowing the railing to move back and forth when touched.	A 042		
A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire	A 043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 043	Continued From page 28	A 043		

resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core.
[7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
Refer to 7.8.2.43 A. (1)

Based on observation and interview, the facility failed to ensure that penetrations and holes in a hazardous area (fuel fired water heater room) in two (2) fire rated walls and ceiling, were properly sealed with approved fire suppression material and failed to maintain a self closing device on the laundry room door. This deficient practice presents a risk to all 12 (R #s 1-12) residents as identified on the resident census list provided by the Administrator on 04/26/16 and all occupants of the building, from smoke and fire passing through the fire rated wall and ceiling or through the door from these hazardous areas in the event of a fire. The findings are:

A. On 04/28/16 at 9:40 am, during a tour of the facility with the Administrator and the head of maintenance, it was observed that there were several penetrations and holes through the walls and ceiling of the fuel fired water heater room for wiring and for pipes that were not sealed. There were two 8 inch round pipes open on each end with one end of each in the hot water heater room and the other ends open into the attic. These two pipes were suppose to go all the way through the roof of the building for combustion air for the fuel fired hot water heaters and not have any openings from this room to the attic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 043	Continued From page 29 B. On 04/28/16 at 9:40 am, during a tour of the facility with the Administrator and the head of maintenance, it was observed that the fire rated solid core wood door to the laundry would not close on it own and would stand open unless shut manually. C. On 04/28/16 at 9:40 am, during an interview with the head of maintenance and the administrator, while touring the facility, the head of maintenance confirmed that there were several penetrations and holes through the walls and ceiling of the fuel fired water heater room that were not sealed and confirmed the two 8 inch round pipes only extend as far as the attic allowing fire and smoke to spread throughout the building in the event of a fire in this hazardous area. The administrator also confirmed that the laundry room door would not shut on it's own.	A 043		
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.62 & National Fire and Protection Association (NFPA) 13	A 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 062	Continued From page 30 Reference NFPA 13 Section 1-5.1 Maintenance: A sprinkler system installed under this standard shall be properly maintained for efficient service. The owner is responsible for the condition of the sprinkler system and shall use due diligence in keeping the system in good operating condition. Reference: NFPA 13, Sect. 1-6.1 states that a building, where protected by an automatic sprinkler system installation, shall be provided with sprinklers in all areas. Reference NFPA 25, 1-4.2 The responsibility for properly maintaining a water-based fire protection system shall be that of the owner(s) of the property. By means of periodic inspections, tests, and maintenance, the equipment shall be shown to be in good operating condition, or any defects or impairments shall be revealed. Inspection, testing, and maintenance shall be implemented in accordance with procedures meeting or exceeding those established in this document and in accordance with the manufacturer's instructions. These tasks shall be performed by personnel who have developed competence through training and experience. Reference NFPA 25, 1-4.4 The owner or occupant promptly shall correct or repair deficiencies, damaged parts, or impairments found while performing the inspection, test, and maintenance requirements of this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. Based on observation, record review, and interview, the facility failed to ensure the	A 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 062	Continued From page 31	A 062		

following:
1. the roof on the front resident porch protected from fire by the automatic fire sprinkler system in accordance with NFPA 13, (Standard for the Installation of Sprinkler Systems);
2. maintain the sprinkler heads throughout the building; and
3. have the sprinkler system inspected quarterly.
Not providing sprinklers in all required areas, not maintaining sprinkler heads, and not having inspections as required, could result in spread of fire from these areas to the resident rooms and/or other areas of the facility, which presents the risk of potential harm to all 12 (R #s 1-12) residents, as identified by the resident census list provided by the Administrator on 04/26/16, and all occupants of the building. The findings are:

A. On 04/28/16 at 11:00 am, during observation, the roof on the front resident porch, was not protected from fire by the automatic fire sprinkler system.

B. On 04/28/16 at 11:00 am, during observation, several sprinkler heads throughout the building had dropped down leaving a gap around them in the dry wall.

C. Record review of facility inspection records revealed the automatic fire sprinkler system was inspected in January, 2015, May, 2015, and September, 2015. This is a period of 4 months between inspections and no inspections for the past 7 months. There were no other inspection records available; therefore, there was no documentation that the system was inspected quarterly (every 3 months) or bi-annually (every 6 months) as required.

D. On 04/26/16 at 11:35 am, during interview,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 062	Continued From page 32 the Administrator acknowledged there were several sprinkler heads throughout the building that needed to be sealed around, the system had not been inspected as required, and stated she was unaware the roof over the porch needed to be protected by sprinklers.	A 062		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.63 A. (3) Based on observation and interview, the facility failed to maintain all portable fire extinguishers in	A 063		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

(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 33 accordance with NFPA 10 Standard for Portable Fire Extinguishers. This failed practice may result in the failure of the portable fire extinguishers to operate, in the event of a fire. This has the potential to harm all 12 (R #s 1-12) residents as identified on the census list provided by the Administrator on 04/26/16. The findings are: A. On 04/26/16 at 12:00 pm, during tour of the facility it was observed that all portable fire extinguishers had not been serviced annually by an authorized contractor and were not inspected monthly by staff. The last service date was January 2015. B. On 04/28/16 at 8:55 am, during an interview with the Administrator, she confirmed the fire extinguishers had not been serviced annually by an authorized contractor and were not inspected monthly by staff.	A 063		
A 064	7 NMAC 8.2.64 Fire Safety Equivalency System Rating FIRE SAFETY EQUIVALENCY SYSTEM RATING: In facilities without a sprinkler system; the fire safety equivalency system shall be conducted at least annually. The facility shall maintain an evacuation rating score of prompt when a fire safety equivalency system is required. [7.8.2.64 NMAC - Rp, 7.8.2.19 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have a Fire Safety Equivalency System (FSES) survey for the facility's 12 (R #1 through	A 064		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ___ B. WING ___	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 064	Continued From page 34 12) residents, as identified by the resident census list provided by the Administrator on 04/26/16. This failed practice may lead to injury and/or death by fire of residents if there is not adequate staff to assist in the evacuation process. The findings are: A. Review of facility records revealed no FSES survey for the Residents. B. On 04/28/16 at 2:30 pm, during an interview, the Administrator confirmed the facility does not have an FSES survey for the Residents.	A 064		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010]	A 065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ____ B. WING ____	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 065	Continued From page 35	A 065		

This REQUIREMENT is not met as evidenced by:
Refer to 7.8.2.65 A. & B. (2)

Based on record review and interview, the facility failed to complete the following:
1. conducting fire drills on each shift for each quarter for the past year;
2. having monthly fire drills;
3. documenting if the fire alarm was used to conduct the drills; and
4. evacuating resident during any of the drills.
This failed practice may result in the staff not being prepared to carry out a safe evacuation of residents and notification of the fire department in the event of a fire. This has the potential to harm all 12 (R #s 1-12) residents, as identified on the resident list provided by the Administrator on 04/26/16 and all occupants of the building. The findings are:

A. Record review of the facility's fire drill records revealed the following:
1. Dates and times of the fire drills for the last 12 months were 04/30/15 at 2:00 pm (day shift), 08/31/15 at 1:00 pm (day shift), 10/01/15 at 8:00 am (day shift), 01/30/16 at 3:20 pm (evening shift), 04/26/16 at 5:04 pm (evening shift); therefore there were 7 of the last 12 months that there were no fire drills. There were no fire drills during the 11:00 pm to 7:00 am shift (night shift), 3 were on the 7:00 am to 3:00 pm shift (day shift) and 2 were on the 3:00 pm to 11:00 pm shift (evening shift) when there should be 1 each quarter (every 3 months) on each shift, which should be 4 total on each shift for a 12 month period.
2. No documentation that the fire alarm was used only 4 of 5 fire drills in the past 12 months

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 065	Continued From page 36 once during one of these drills on 01/30/16; and 3. No documentation that evacuation of the residents was done during these drills. B. On 04/28/16 at 2:30 pm, during interview, the Administrator confirmed that the fire drills were not completed monthly or during each shift quarterly, that the fire alarm had only been tested during one drill, and no evacuation of the residents was done during any of the drills.	A 065		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 37 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, including the name, address, date of birth, social security number, and other appropriate identifying	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 38 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 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ____ B. WING ____	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 39 Based on record review and interview, the facility failed to ensure that Direct Care Staff (DCS) met the Employee Abuse Registry requirements (EAR) for 5 (DCS #2, 4, 7, 9, & 11) of 11 (DCS #1 through #11) direct care staff files reviewed for EAR. This deficient practice has the potential to affect all residents by allowing a person who has been placed on the registry for abuse, neglect, and/or exploitation of an adult to have access to vulnerable adults. The findings are: A. Record review of 5 DCS records revealed that inquiry to the NM/DOH/EAR was not done prior to the date of hire for the following: 1. DCS #2 date of hire was 10/16/15 and inquiry was not done until 10/24/15; 2. DCS #4 date of hire was 08/04/14 and inquiry was not done until 08/08/15; 3. DCS #7 date of hire was 06/12/15 and inquiry was not done until 06/17/15; 4. DCS #9 date of hire was 09/29/15 and inquiry was not done until 10/04/15; 5. DCS #11 date of hire was 09/09/15 and inquiry was not done until 10/04/15; B. On 04/27/16 at 3:00 pm during interview the Administrator, she confirmed inquiry to the registry was not getting completed prior to the date of hire for facility staff. Refer to 7.6.2.10 G. (3) Exhaust hoods, or other ventilation devices required by applicable codes shall be designed, installed, and maintained to prevent grease or condensate from dripping into food or on to food preparation surfaces. Filters shall be kept clean and in good repair.	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ______ B. WING ______	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	**801 W CHERRY LANE CARLSBAD, NM 88220**

(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 40	A 070		

Refer to National Fire and Protection Agency (NFPA) 96, " Standard for Ventilation Control and Fire Protection of Commercial Cooking Operation

The fire protection system requires annual and semi-annual inspections.
The cooking exhaust system requires quarterly cleaning. This includes from the origin (filters and hood) the run (Duct from hood to exhaust) and the terminus (Exhaust fan). This shall be done by an authorized contractor who places a sticker on the end of the hood with the company name, date of cleaning and next scheduled date. The facility can do this themselves but, they have to clean not only the filters but the entire system from the origin, run and terminus and they SHALL document this, keeping records to be made available to the inspector.

Based on record review, observation, and interview the facility failed to protect the health and safety of the facility's 12 (R #1 through 12) residents as identified by the resident census list provided by the Administrator on 04/26/16 by not having the following:

1. documentation the cooking exhaust system was cleaned quarterly;
2. documentation the cooking exhaust system had been inspected semi-annually.

This deficient practice could lead to grease fire in the cooking exhaust system putting all residents and occupants of the building in danger. The findings are:

A. On 04/28/16 at 9:00 am, during a tour of the facility there was no sticker on the cooking exhaust system signifying it had ever been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2117	A. BUILDING: ____ B. WING ____	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE SENIOR LIVING AND MEMORY CARE	801 W CHERRY LANE CARLSBAD, NM 88220

(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 41 cleaned. B. Record review of facility inspection records revealed the cooking exhaust system was inspected and serviced on 06/30/15 and not again until 04/26/16; therefore not inspected semi-annually. C. On 04/28/16 at 9:00 am, during an interview with the Administrator and her Assistant, they acknowledged there was no documentation of quarterly cleaning of the cooking exhaust system and were unaware of this requirement. They further acknowledged the cooking exhaust system went for 10 months without a semi-annual inspection.	A 070		