STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: _____ B. WING _____	C 04/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Complaint survey conducted 04/22/22, for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint Intake #NM57400 was substantiated with deficiencies cited.	A 000		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being;	25 A 0		

Melissa Vallejos Administrator 05/26/2022

Division of Health Improvement

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: _____ B. WING _____	C **04/22/2022**

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

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

A 025	Continued From page 1 (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A E Based on record review and interview, the facility failed to ensure for 2 (R #s 1 and 3) of 3 (R #s 1-3) residents whose Evaluations were reviewed for compliance that they were:	A 025		

Division of Health Improvement

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: B. WING _____	C 04/22/2022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 2 1. Completed within 15 days prior to admission. 2. Reviewed by a Licensed Practical Nurse (LPN), Registered Nurse (RN) or Physician Extender (PE). These deficient practices could likely result in the residents not receiving appropriate care/services upon admission, if the Direct Care Staff (DCS) are not aware of what the resident's needs are. The findings are: A. Record review of R #1's Evaluation dated 04/18/22, revealed it had not been: 1. Completed within 15 days prior to admission on [redacted]/22. 2. Reviewed by a LPN, RN, or PE. B. Record review of R #3's Evaluation dated 03/31/22, revealed it had not been reviewed by a LPN. RN, PE. C. On 04/19/22 at 2:36 pm, during an interview with the Regional Operations Manager, she confirmed that: 1. R #1's Evaluation had not been completed within 15 prior to admission. 2. R #1's Evaluation had not been reviewed by a LPN, RN, or PE. 3. R #3's Evaluation had not been reviewed by a LPN, RN, or PE. .	A 025	Immediately took action to ensure that evaluations are completed 15 days prior to admission and will be reviewed by a LPN, RN or PE. Will in the future ensure that evaluations will be completed 15 days prior to admission and will be reviewed by a LPN, RN or PE. Will ensure that evaluations are completed 15 days prior to admission for all new residents and will be reviewed by a LPN, RN or PE to be in compliance for the state of New Mexico. Administrator or Nurse will monitor prior to an admission that an evaluation is completed 15 days prior to admission and will be reviewed by the LPN, RN or PE and the evaluation will be placed in the resident's chart. Corrective action is completed.	05/26/2022
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	A 026		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: _____ B. WING _____	C 04/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 026	Continued From page 3 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. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 026		

Division of Health Improvement

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: B. WING _____	C **04/22/2022**

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

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

A 026	Continued From page 4 7.8.2.26 A (2) Based on record review and interview, the facility failed to ensure for 2 (R #s 1 and 3) of 3 (R #s 1-3) residents whose Individual Service Plans (ISPs) were reviewed for compliance were: 1. Completed within 10 days after admission to the facility 2. Reviewed and if needed revised by a Licensed Practical Nurse (LPN), Registered Nurse (RN) or a Physician Extender (PE) These deficient practices could likely result in residents not receiving appropriate care/services if the Direct Care Staff (DCS) are not aware of what the resident's needs are. The findings are: A. Record review of R #1's ISP dated 04/19/22, revealed it had not been: 1. Completed within 10 days after admission to the facility on [redacted]/22. 2. Reviewed by a LPN, RN, or PE. B. Record review of R #3's ISP dated 03/31/22, revealed it was not completed/reviewed by a LPN, RN, or PE. C. On 04/19/22 at 2:36 pm, during an interview with the Regional Operations Manager, she confirmed that: 1. R #1's ISP was not completed within 10 days after admission to the facility or reviewed by a LPN, RN, or PE 2. R #3's ISP was not completed/reviewed by a LPN, RN, or PE. 7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS:	A 026	Immediately took action to ensure that an ISP will be completed within 10 days after admission and will be reviewed and revised by a LPN, RN or PE. Will in the future ensure that an ISP will be completed within 10 days after admission and will be reviewed and revised by a LPN, RN or PE. Will ensure that an ISP is completed within 10 days after admission and will be reviewed and revised by a LPN, RN or PE.. Administrator or Nurse will monitor a new an admission to ensure that an ISP is completed within 10 days after admission and will be reviewed and revised by a LPN, RN or PE. The ISP will be placed in the resident's chart upon completion. Corrective action is completed.	05/26/2022
A 032		A 032		

Division of Health Improvement

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: B. WING _____	C 04/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 5 A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 B 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS	A 032		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: B. WING _____	C **04/22/2022**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 6 Refer to 7.1.13.7 W. & 8 B. (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor ' s order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division ' s incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau ' s incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure that investigation follow-up reports were submitted to the Licensing Authority within 5 business days from the date an incident occurred. . This deficient practice could likely result in the 8	A 032	Immediately took action to ensure that investigation follow-up reports are submitted to the Licensing Authority within 5 business days from the date an incident occurred. Will in the future ensure that investigation follow-up reports are submitted to the Licensing Authority within 5 business days from the date an incident occurred. Will ensure that investigation follow-up reports are submitted to the Licensing Authority within 5 business days from the date an incident occurrs. Administrator will ensure that investigation follow-up reports were submitted to the Licensing Authority within 5 business days from the date an incident occurred. Corrective action is completed.	05/26/2022

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: _____ B. WING _____	C 04/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 7 (R #s 1-8) residents identified on the census provided by the Administrator on 04/12/22, to be at risk of harm, injury, and/or death, if incidents occur, internal investigations were not completed, and there is no oversite by the Licensing Authority. The findings are: A. Record request for documentation that the facility completed an internal investigation and submitted an investigation follow-up report for intake NM#57400 revealed: 1. The facility self-reported an incident of missing expired/discontinued narcotic medications on 02/18/22. 2. The facility did not submit a follow-up complaint investigation report to the Licensing Authority within 5 business days from the date of the incident. B. On 04/19/22 at 2:36 pm, during an interview with the Regional Operations Manager, she confirmed that the 5 day follow-up report for NM #57400 was not completed or submitted to the Licensing Authority. 7 NMAC 8.2.33 Resident Rights	A 032		
A 033	RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights	A 033		

Division of Health Improvement

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: _____ B. WING _____	C 04/22/2022

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

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

A 033	Continued From page 8 shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor;	A 033		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: B. WING _____	C **04/22/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 9 and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s);	A 033		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: B. WING _____	C 04/22/2022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 10 (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (11) (a) Based on record review and interview, the facility failed to ensure that resident medications were stored in a manner which protected them from misappropriation/exploitation. This deficient practice could likely result in the 8 (R #s 1-8) residents listed on the census provided by the Administrator on 04/12/22, to be at risk of harm, injury, or death, if they did not receive their prescribed medications because they were missing. The findings are:	A 033	Immediately took action to ensure that resident medications are stored in a manner which protected them from misappropriation/exploitation. Will in the future ensure that resident medications are stored in a manner which protects them from misappropriation/exploitation. Administrator or Nurse will have all new staff trained to ensure that resident medications are stored in a manner which protects them from misappropriation/exploitation. Administrator or Nurse will monitor daily resident medications and ensure they are stored in a manner which protects the meds from misappropriation/exploitation. Corrective action is completed.	05/26/2022

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: _____ B. WING _____	C 04/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 11 A. On 04/12/22 at 10:59 am, during an interview with the former Registered Nurse (RN), she stated that: 1. On 03/14/22 at 8:00 am, she was informed that the following medications were missing for R #5: [redacted] 2. R #5's medications were correctly reconciled (counted and documented) by Direct Care Staff (DCS) #6 and #8 at 6:00 am on 03/14/22. 3. R #5's medications went missing from the medication cart sometime between 6:30 am and 7:00 am on 03/14/22. 4. She submitted an external incident report to the New Mexico Department of Health regarding the incident on 03/14/22. 5. She conducted an investigation and was unable to definitively identify any who was responsible for taking R #5's medications. B. On 04/18/22 at 2:18 pm, during an interview with DCS #6, she confirmed that: 1. She and DCS #8 counted and reconciled R #5's medications at 6:00 am and there were none missing. 2. R #5's medications went missing sometime between 6:30 am and 7:00 am when she went to the memory care unit to assist with medications. 3. She was not responsible for taking R#5's medications. 4. She did not know who was responsible for taking R #5's medications. 5. R #5 did not miss [redacted] medications	A 033		

Division of Health Improvement

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: _____ B. WING _____	C **04/22/2022**

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

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

A 033	Continued From page 12 because: a. There was overstock of Hydrocodone. b. She did not require [redacted] on 03/14/22. C. On 04/20/22 at 3:40 pm, during an interview with DCS #8, she confirmed that: 1. She and DCS #6 counted and reconciled R #5's medications at 6:00 am and there were none missing. 2. R #5's medications went missing sometime between 6:30 am and 7:00 am. 3. She was not responsible for taking R #5's medications. 4. She did not know who was responsible for taking R #5's medications. D. Record review of an external incident report to the NMDOH dated 03/14/22 revealed: 1. The former registered nurse sent in an incident report to NMDOH on 03/14/22. 2. The report stated R #5's [redacted] were counted at 6:00 am by DCS #6 and DCS #8 and the count was correct. 3. When DCS #6 went to pass medications at 7:15 am, she noticed R #5's [redacted] were missing. E. Record review of R #5's narcotic shift log count for [redacted] revealed: 1. It was received on 03/12/22 with a count of 14. 2. There were no missing doses and the last dose was given on 03/18/22 with one dose remaining. F. On 04/19/22 at 2:36 pm, during an interview with the Administrator, she confirmed that: 1. The medications were missing on 03/14/22 for R #5.	A 033		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2116	A. BU LDING: B. WING _____	C **04/22/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 13 2. She did not know who was responsible for taking R #5's medications. G. On 05/20/22 at 10:47 am, during an interview with the Administrator, she stated the facility did not have the narcotic medication count sheets and they were missing when R #5's medications went missing.	A 033		