

Division of Health Improvement

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>2117 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/25/2024 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>GOOD LIFE SENIOR LIVING AND MEMORY CARE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>801 W CHERRY LANE<br>CARLSBAD, NM 88220 |
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| A 000              | <p>Initial Comments</p> <p>The following deficiency was cited during a Complaint survey completed on 06/25/24 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living Facilities for Adults.</p> <p>Census: ■</p> <p>Complaint Intake NM ■ was investigated, with no deficiencies cited.</p> <p>Complaint Intake NM ■ was investigated, with deficiencies cited.</p>  | A 000         |   |                    |
| A 032              | <p>7 NMAC 8.2.32 Reporting of Incidents</p> <p>REPORTING OF INCIDENTS:</p> <p>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.</p> <p>(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.</p> <p>(2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted.</p> <p>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:</p> <p>(1) a narrative description of the incident;</p> <p>(2) the result of the facility's investigation shall be</p> | A 032         |   |                    |

Division of Health Improvement  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Julie Fox*

Administrator

TITLE

8/23/2024

(X5) DATE

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| A 032              | <p>Continued From page 1</p> <p>recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and</p> <p>(3) plans for further actions in response to the incident.</p> <p>[7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by:<br/>7.8.2.32 A (1) B</p> <p>7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS</p> <p>Refer to 7.1.13.7 W. and 8 B. (2)</p> <p>A. "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.</p> <p>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</p> | A 032         |   |                    |

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| A 032              | <p>Continued From page 2</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure for 1 (R #1) of [REDACTED] (R #'s 1-[REDACTED]) residents whose resident files were reviewed for compliance that the facility:</p> <ol style="list-style-type: none"> <li>1. Reported incidents of possible abuse, neglect, exploitation, or unusual occurrences that have threatened or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday.</li> <li>2. Conducted an internal investigation and submitted an investigation follow-up report to the Licensing Authority within five (5) business days from the date an incident occurred.</li> </ol> <p>These deficient practices could likely put the residents at risk of harm, injury, or death if incidents occur and there is no oversight by the Licensing Authority. The findings are:</p> <p>A. Record review of R #1's Hospital Emergency Department record dated 06/21/23 revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 06/21/23, at an undocumented time, the facility nurse found R #1 on the floor after the resident experienced a fall at the facility, which resulted in a [REDACTED]</li> <li>2. On 06/21/23, R #1 was transported to the Emergency Room (ER); at that time R #1 had an</li> </ol> | A 032         |   |                    |

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| A 032              | <p>Continued From page 3</p> <p>X-ray (powerful waves of energy that can show images of the human body) and a CAT Scan (a special X-ray machine that takes detailed pictures of the inside of the body).</p> <p>B. Record review of R #1's Hospital Emergency Department records dated [REDACTED]/23 revealed:</p> <ol style="list-style-type: none"> <li>1. The facility nurse found R #1 face down and nonresponsive on the floor after experiencing an unwitnessed fall.</li> <li>2. R #1 was transported to the Emergency Room (ER) because of the fall.</li> <li>3. The facility's Licensed Practical Nurse (LPN) reported to the Hospital Emergency Department that:               <ol style="list-style-type: none"> <li>a. R #1 had a history of [REDACTED]</li> <li>b. In the last (3) three months, R #1 started falling more often due to an increase in [REDACTED]</li> <li>c. When R #1 ambulates (walk), the resident requires assistance physically walking and often needed assistance with direction.</li> </ol> </li> <li>4. R #1's hospital discharge plan included:               <ol style="list-style-type: none"> <li>a. A prescription for [REDACTED]</li> <li>b. A prescription for a Hospital bed ( a bed having rails that can be raised or lowered and a mattress base in three jointed sections so that the head, foot, or middle can be raised or lowered) to be used by R #1 when discharged</li> </ol> </li> </ol> | A 032         |   |                    |

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| A 032              | <p>Continued From page 4</p> <p>back to the facility.</p> <p>b. A directive for the facility to monitor R #1s blood pressure.</p> <p>C. Record request for internal (facility-created) incident reports regarding R #1's falls in the facility revealed that the facility did not have internal incident reports available for review.</p> <p>D. Record requests for the facility's internal incident reports submitted to the Licensing Authority regarding R #1 falls in the facility revealed that the facility did not document and submit incident reports.</p> <p>E. On 06/13/24 at 3:00 pm, during an interview, the Administrator confirmed:</p> <ol style="list-style-type: none"> <li>1. R #1 experienced unwitnessed falls in the facility due to a decline in both mental and physical conditions.</li> <li>2. R #1 was transported to the hospital for evaluation after experiencing unwitnessed falls.</li> <li>3. The facility did not report R #1's unwitnessed falls to the Licensing Authority.</li> <li>4. The facility did not conduct internal investigations of the falls/incidents and did not submit investigation follow-up reports to the Licensing Authority within five (5) business days from the incidents.</li> </ol> | A 032         | <p>Facility administrator will ensure internal reports are sent to licensing authority; Facility nurse will ensure 5 day follow up is complete after the internal investigation is conducted including the admin. Admin will ensure 5 day follow up is sent to licensing authority.</p> <p>A monthly check of any reportable incidents will be completed at the end of the month with nurse and administrator to ensure compliance.</p> <p>Facility Administrator and Nurse will train staff for future incidents on the process of reporting to the licensing authority and the steps on how to report to licensing authority on a bi-monthly basis.</p> | 8/23/2024          |