STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325103	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Farmington	1101 West Murray Drive Farmington, NM 87401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49196 Based on record review and interview, the facility failed to report unwitnessed falls resulting in injury (an indicator of possible neglect or abuse) to the State Survey Agency, for 2 (R #7 and R #10) of 3 (R #7, R #8, and R #10) residents reviewed for falls. This deficient practice is likely to result in the State Survey Agency not being aware of facility incidents and unable to assure residents have a safe and hazard free environment. The findings are: A. Record review of facility provided fall reports included: - R #10 experienced an unwitnessed fall on 12/05/2024 resulting in an abrasion (skin damage due to scraping) on his right knee and hematoma (pooling of mostly clotted blood under the surface of the skin) on his face. - R #10 experienced an unwitnessed fall on 01/18/2024 resulting in lacerations (cuts or tears) on his forehead and the bridge of his nose, as well as, bruising and swelling on his left hand, wrist, and forearm. - R #7 experienced an unwitnessed fall on 01/28/2024 resulting in an abrasion on his left knee. - R #7 experienced an unwitnessed fall on 02/04/2024 resulting in a hematoma on his right elbow and a laceration on the back of his head. B. Review of Facility Incident Reports (FIRs) submitted to the State Survey Agency (SSA) indicated the facility did not submit a FIR for the incidents listed in finding A. C. On 03/01/2024 at 11:30 am during an interview, the Director of Nursing (DON) explained the facility did not submit a facility report for these incidents, because they did not result in a serious injury, such as a fracture or hospital admittance.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49196 Based on observation, interview, and record review, the facility failed to develop comprehensive, person-centered care plans which included information about current fall prevention strategies being used for 2 (R #7 & R #10) of 3 (R #7, R #8, and R #10) residents reviewed for care plans. This deficient practice could likely result in residents not receiving the care needed to reach their highest practicable level of well-being. The findings are: Resident #7 A. Record review of R #7's health status note by LPN #5 in the Electronic Medical Record (EMR), dated 02/20/2024, stated the resident stayed at the nurse's station for observation while he struggled to fall back to sleep. B. Record review of R #7's care plan, dated 12/21/2023, indicated that placing the resident at the nurse's station for increased observation was not listed as an intervention. Resident #10 C. On 02/29/2024 at 5:45 pm, R #10 sat at the nurse's station in his wheelchair and propelled himself slowly in circles. D. Record review of R #10's care plan, dated 01/24/2024, indicated placing the resident at the nurse's station for increased observation was not listed as an intervention. E. On 03/01/2024 at 11:30 am during an interview, the Director of Nursing (DON) explained placing residents at the nurse's station for increased observation was a fall prevention strategy used for R #7 and R #10, both of whom have a history of impulsive behavior leading to frequent falls. The DON confirmed this intervention was not listed in either resident's care plans. The DON was uncertain if this should or should not be included in residents' care plans.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48645 Based on observations and interviews the facility failed to: 1. Ensure all medication carts were locked when not in use. This deficient practice is likely to affect all 35 residents in A hall, identified on the census list provided by the Executive Director (ED) on 2/28/24, by allowing unauthorized persons access to their medications and personal health information. The findings are: Findings for unlocked medication cart. A. On 02/29/24 at 3:52 pm, during observation, the A hall medication cart was unlocked and accessible. Observation also revealed the staff did not use or control the cart, for five minutes. Further observation revealed the nearby nurses station was also vacant during this time. B. On 02/29/24 at 4:00 pm during an interview with Licensed Practical Nurse (LPN #2), she stated the medication cart was hers, and it should be locked.