

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Farmington		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632</p> <p>Based on record review and interview, the facility failed to notify the family member/Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care) for 1 (R #1) of 3 (R #1, #2, and #3) residents when changes in R #1's medication were made. If the facility is not notifying the resident's POA when the resident has a change in medication, then the POA is unable to make decisions related to treatment and advocate for the resident's care. The findings are:</p> <p>A. Record review of R #1's face sheet indicated R #1 was admitted to the facility on [DATE] and was discharged on [DATE]. R #1 had the following diagnoses:</p> <ul style="list-style-type: none"> - Alzheimer's disease (causes memory loss, language loss and impaired judgement), - Anxiety (feelings of fear or apprehension), - Depression (causes persistent feeling of sadness and loss of interest), - Dementia with psychotic disturbance (a decline in thinking and problem solving skills as well as delusions or hallucinations). <p>B. Record review of R #1's physician's orders indicated the following:</p> <ul style="list-style-type: none"> - Buspirone (anxiety medication) HCl oral tablet 5 milligrams (mg). Give one tablet at bedtime for anxiety. Start on 10/09/24 and end on 10/22/24. - Trazodone (anti-depressant and sedative) HCl oral tablet 100 mg. Give one tablet at bedtime for depression. Start date 10/09/24 and end on 10/14/24. - Buspirone HCl oral tablet 5 mg. Give one tablet three times per day for anxiety. Start date on 10/22/24 and ended on 11/22/24. - Trazodone HCl oral tablet 100 mg. Give two tablets at bedtime for depression. Start date 10/14/24 and ended on 11/22/24. <p>(continued on next page)</p>

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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>C. Record review of R #1's medical record revealed it did not contain documentation to show staff notified the resident's family/POA of the increase in the medications for the resident's buspirone and trazodone.</p> <p>D. D. On 01/07/25 at 1:31 pm, during an interview with family member (FM)/Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care), she stated the facility's communication was lacking. The FM/POA stated the facility would increase R #1's medications, but they did not notify her of it. She stated some of R #1's medications increased by double the amount. She stated she was not aware they were increasing R #1's medications, and the staff did not ask her if she wanted medications increased. The FM/POA stated she asked staff about R #1's medications, but they told her they did not know the answers. She stated she had one conversation with the physician about some of her concerns regarding R #1's medication, and that was the only time she spoke to anyone about R #1's medications. The FM/POA stated she went to the pharmacist to fill the prescriptions for R #1 after the resident discharged from the facility, and the pharmacist told her a few of the prescriptions were really high doses. She stated that was how she found out about some of R #1's medications. The FM/POA stated she called the Director of Nursing (DON) about R #1's medication, but she did not get an answer as to why the resident's medications were increased.</p> <p>E. On 01/07/24 at 3:00 pm during an interview with the Director of Nursing (DON), she stated staff should notify the family anytime there was a change in medication, prior to the medication change. The DON stated if the family member/POA agreed to the medication change then a verbal consent should be given. The DON stated staff should enter a progress note into the resident's medical record. She stated staff did not notify R #1's family/POA of the medication changes, and the resident's medical record did not contain documentation the POA gave verbal consent for the medication changes.</p> <p>F. On 01/08/24 at 9:05 am, during an interview with Nurse #1, she stated the medication increase for R #1 was due to behaviors, because R #1 had a lot of anxiety at night. Nurse #1 stated the resident would push her call light frequently, needing to be turned. She stated sometimes she would go to R #1's room with the Certified Nursing Assistants (CNAs). Nurse #1 stated R #1 would not lay on her back and wanted to be on her side. She stated the medication increase was due to behaviors. Nurse #1 stated that she did not notify the daughter/POA of the increase in medication, and she did not know why.</p>		