

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/30/2026
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)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were free from unnecessary medications, in accordance with professional standards of practice, for 1 (R #1) of 1 (R #1) resident, when: A medication consent form was not completed as required before administration of a psychotropic medication (medication used to treat mental health conditions).A psychotropic medication gradual dose reduction (GDR; tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose) was not attempted or supported by documentation indicating a clinically contraindicated reason likely to impair function or cause psychiatric instability in the resident.This deficient practice is likely to result in residents being administered psychotropic medications that are unnecessary resulting in possible sedation and other unwanted side effects. The findings are: A. Record review of the facility's psychotropic medication use policy, revised on 03/01/25, revealed the following: Facility staff should inform the resident and/or representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy or applicable state regulations. Physician/prescriber should document the clinical rationale for why any additional attempted dose reduction at that time would likely to impair the resident's function or increase distressed behavior. B. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), revealed R #1 was admitted on [DATE] with a diagnosis of cerebrovascular accident (CVA; stroke) and dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment). R #1's Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) showed a score of 02, indicating R #1 had severe cognitive impairment. C. Record review of R #1's physician orders revealed the following: Dated 09/20/24, R #1 was prescribed trazodone (antidepressant and sedative), 50 milligrams (mg), give two tablets by mouth at bedtime for depression. This medication was discontinued on 07/07/26. Dated 07/07/26, R #1 was prescribed trazodone, 50 mg, give 1.5 tablets by mouth at bedtime for depression for 14 days. This medication was discontinued on 07/20/26. Dated 07/23/26, R #1 was prescribed trazodone, 50 mg, give 1.5 tablets by mouth at bedtime for depression for 14 days. D. Record review of R #1's medication informed consent form, dated 03/03/25, revealed a medication consent was obtained for R #1's trazodone 50 mg use, which began on 09/20/24. A medication consent form was not obtained prior to this form. E. Record review of R #1's pharmacist consultation reports, revealed the following: Dated 04/23/26, the pharmacist recommended a GDR for R #1's use of trazodone to 75 mg by mouth every night at bedtime. The facility provider declined the pharmacist's recommendation, and the rationale provided by the provider for why a GDR attempt was likely to impair function or cause psychiatric instability in the resident was documented as Family routinely declines GDRs.Dated (continued on next page)		

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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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/30/26, the pharmacist recommended a GDR for R #1's use of trazodone to 75 mg by mouth every night at bedtime. The facility provider accepted the pharmacist's recommendation. F. Record review of R #1's medication administration record (MAR), dated 01/01/26 through 07/29/26, revealed R #1 was administered trazodone per physician orders each day he was in the facility. G. On 07/28/26 at 2:43 pm, during an interview, R #1's Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care) stated there were times she was not contacted by the facility for a medication consent before R #1 received the medication. The POA stated whenever a medication consent form is required, she should be contacted immediately rather than months later, after the medications have already been administered. H. On 07/29/26 at 3:50 pm, during an interview, Registered Nurse (RN) #1 stated the nurse responsible for entering the medication order is required to obtain a medication consent from the resident, the resident's POA, or family before administering the medication. I. On 07/29/26 at 4:23 pm, during an interview, Licensed Practical Nurse (LPN) #1 stated after the provider ordered the medication, nursing staff were required to obtain a medication consent from the resident, the resident's POA, or family before administering the medication. LPN #1 stated it was the nurse's responsibility to obtain a completed medication consent form prior to administering a psychotropic medication. J. On 07/30/26 at 1:31 pm, during an interview, the pharmacist stated medication consent forms are required before administering psychotropic medications. The pharmacist stated the resident's family is included in discussions about the resident's medications, but the provider is ultimately responsible for a GDR and determining what is best for the resident. K. On 07/30/26 at 2:05 pm, during an interview, the Director of Nursing (DON) stated a medication consent form is required before administering medication. The DON stated R #1's medication consent form for trazodone was not completed before administration and should have been. The DON stated a GDR was implemented at a later date for R #1's trazodone use due to R #1's family. The DON stated documenting family routinely declines GDRs as the reason for not attempting a GDR on the pharmacist recommendation dated 04/23/26 did not indicate whether the decline was based on a concern the recommendation was likely to impair function or cause psychiatric instability in the resident, as required.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to meet professional standards of quality for 1 (R #1) of 1 (R #1) resident, when staff failed to follow the physician orders for placement of R #1's urinary catheter (a thin, flexible tube which drains urine from the bladder) collection bag (also called a drainage bag; a device connected to the catheter tubing and collects urine). This deficient practice is likely to result in residents not maintaining their optimal health as planned by their medical provider. The findings are: A. Record review of the facility's physician order policy, revised on 02/11/26, revealed a physician, physician assistant, or nurse practitioner must provide orders for the resident's immediate care and ongoing care of the resident. The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines. B. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), revealed R #1 was admitted on [DATE] with a diagnosis of cerebrovascular accident (CVA; stroke), dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), and neurogenic bladder (the bladder does not empty properly due to a neurological condition). R #1's Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) showed a score of 02, indicating R #1 had severe cognitive impairment. C. Record review of R #1's physician order, dated 03/10/25, directed staff to check R #1's urinary catheter tubing and drainage bag placement every shift to ensure proper placement below the knee for optimal gravity drainage. D. Record review of R #1's care plan, dated 12/22/25, revealed R #1 used a urinary catheter and directed staff to educate the resident and the resident's family regarding the urinary catheter and its' care. E. On 07/29/26 at 3:44 pm, during an observation, R #1's urinary catheter drainage bag was secured to his right thigh (upper portion of the leg between the hip and the knee) and positioned above his knee while R #1 sat in a wheelchair. F. On 07/29/26 at 3:54 pm, during an interview, Registered Nurse (RN) #1 stated R #1's urinary catheter drainage bag was supposed to be secured below his knee, but R #1's spouse wanted the drainage bag secured above his knee, so staff followed her instructions. G. On 07/29/26 at 4:29 pm, during an interview, Licensed Practical Nurse (LPN) #1 stated R #1's urinary catheter drainage bag was supposed to be secured below his knee, but during the day, nursing staff placed it on his thigh. H. On 07/30/26 at 9:33 am, during an interview, RN #2 stated staff kept R #1's urinary catheter drainage bag above the knee and positioned on his thigh each shift. I. On 07/30/26 at 2:16 pm, during an interview, the Director of Nursing (DON) stated R #1's physician order states R #1's urinary catheter drainage bag should be positioned below R #1's knee, but R #1's spouse wants it secured above R #1's knee. The DON stated nursing staff should follow physician orders as written and not follow instructions from a resident's family member if those instructions contradict the physician order.		