| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 5796 | A. BUILDING: _____ B. WING _____ | C 12/19/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINGSTON RESIDENCE OF SANTA FE | 2400 LEGACY COURT SANTA FE, NM 87507 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY 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<br><br>A Complaint investigation was completed for intake #NM00028244 for NMAC 7.8.2 regulations governing Assisted Living facilities.<br><br>The Complaint was Substantiated.<br><br>A Complaint investigation was completed for intake #NM00028191 for NMAC 7.8.2 regulations governing Assisted Living facilities.<br><br>The Complaint was Unsubstantiated. | A 000 | | |
| A 033 | 7 NMAC 8.2.33 Resident Rights<br><br>RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents.<br>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.<br>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 shall be provided to the most significant responsible party in the following order:<br>(1) the resident's spouse;<br>(2) significant other;<br>(3) any of the resident's adult children;<br>(4) the resident's parents;<br>(5) any relative the resident has lived with for six or more months before admission;<br>(6) a person who has been caring for, or paying benefits on behalf of the resident;<br>(7) a placing agency;<br>(8) resident advocate; or<br>(9) the ombudsman. | A 033 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 5796 | A. BUILDING: _____ B. WING _____ | C 12/19/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINGSTON RESIDENCE OF SANTA FE | 2400 LEGACY COURT SANTA FE, NM 87507 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY 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 1<br>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.<br>D. To protect resident rights, the facility shall:<br>(1) treat all residents with courtesy, respect, dignity and compassion;<br>(2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality;<br>(3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes;<br>(4) provide residents with a safe and sanitary living environment;<br>(5) provide humane care for all residents;<br>(6) provide the right to privacy, including privacy during medical examinations, consultations and treatment;<br>(7) protect the confidentiality of the resident ' s medical record;<br>(8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room;<br>(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;<br>(10) prohibit the use of any and all physical and chemical restraints;<br>(11) ensure that residents:<br>(a) are free from physical and emotional abuse neglect and misappropriation/or exploitation;<br>(b) are free from financial abuse and | A 033 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 5796 | A. BUILDING: _____ B. WING _____ | C 12/19/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINGSTON RESIDENCE OF SANTA FE | 2400 LEGACY COURT SANTA FE, NM 87507 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY 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 2 | A 033 | | |

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);
(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;

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 5796 | A. BUILDING: _____ B. WING _____ | C 12/19/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINGSTON RESIDENCE OF SANTA FE | 2400 LEGACY COURT SANTA FE, NM 87507 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D 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 3<br>and<br>(q) are protected from unjustified room transfers or discharge.<br>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]<br><br>This REQUIREMENT is not met as evidenced by:<br>Refer to 7.8.2.33 - Resident Rights<br><br>Based on record reviews and interviews, the facility failed to ensure that residents (Resident #1 and Resident #2) were provided with a safe environment. The findings are:<br><br>A. Review of Department of Health Intake read that a family member was verbally abusive towards his [redacted] (Resident #1) who lives on the unit and has now become physically abusive with another resident (Resident #2) on the unit within the confines of the facility.<br><br>B. On 12/13/11 at 9:00 am during interview with the Director #1, he reported that since Resident #1's admission to the unit, Visitor #1 had exhibited cyclical patterns of behavioral highs and lows of personality which make [redacted] difficult to deal with, in a general sense. In addition, specific behaviors and ongoing incidents had made Visitor #1 a threat to the safety and welfare of residents. Specifically, Visitor #1 had forcefully physically re-directed and yelled at an [redacted] resident (Resident #2), on | A 033 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 5796 | A. BUILDING: _____ B. WING _____ | C 12/19/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINGSTON RESIDENCE OF SANTA FE | 2400 LEGACY COURT SANTA FE, NM 87507 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D 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 4 | A 033 | | |

the unit. Other multiple incidents of unpredictable, explosive outbursts in which Visitor #1 was yelling at Resident #1, lack of cooperation and ignoring the facility's attempt to go about the business of caring for all residents equally, left the staff on edge when Visitor #1 was in the facility believing that all residents of the unit were at risk.

C. Interview with Nurse #1 (LPN), on 12/19/11 indicated that on various occasions, she had heard Visitor #1 yelling and screaming at Resident #1 horribly. For example, she stated that she remembered some loud fragments of conversations in which she had heard Visitor #1 yell, "How many times do I have to tell you [redacted] "you can't remember [redacted] Nurse #1 reported that these yelling tirades impacted his [redacted] Resident #1, who has an [redacted] She reported that when Visitor #1 left the facility following one of these tirades, Resident #1 had been seen crying, saying, [redacted] but did not remember the source of these tirades as coming from [redacted] son, Visitor #1. She reported that on one occasion (did not remember date), after a tirade and after [redacted] son left the unit, Resident #1 said, [redacted] didn't know why he [Visitor #1] was mad at [redacted] "I don't know what I did." Nurse #1 reported that Visitor #1 was also demanding and abusive of staff. Nurse #1 reported that Visitor #1 yelled at her when Resident #1's tissues ran out and when Visitor #1 came out of [redacted] room he was very rude. Nurse #1 reported that at one time, the caregivers on the unit were preparing to give Resident #1 a shower, not knowing that Visitor #1 was visiting. Nurse #1 reported that he was rude when the caregivers knocked on the door and accused the facility of sending staff to "check" on them when they were in [redacted] room. In yet another

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 5796 | A. BUILDING: _____ B. WING _____ | C 12/19/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINGSTON RESIDENCE OF SANTA FE | 2400 LEGACY COURT SANTA FE, NM 87507 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D 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 5 | A 033 | | |

incident, Nurse #1 recalled Visitor #1 came to pick Resident #1 up and "they [Resident #1 and Visitor #1] got into it." Nurse #1 reported that [redacted] stormed out of the room and came to the nurse's station and reported that, "There will be no yard sales today compliments of [Name of Resident #1]." Finally, she reported that Resident #1 does well on the unit. "I am afraid that if Visitor #1 has too much pressure in [redacted] [and] wonder what Visitor #1 might do. A lot of us [staff] can see how angry Visitor #1 gets, a lot of us have seen it. Everybody is nervous wondering how Visitor #1 is gonna react [when in the facility]."

D. During interview on 12/13/11 at 11:16 am, Director #2 reported that on Saturday, 04/16/11, when he was Manager on Duty for the weekend, he was called out to the Alzheimer's Unit on report of incident. Nurse #1, the nurse on duty, directed him to Visitor #1 who was heard to be "throwing things" behind the closed door of Resident #1's room on the unit. Visitor #1 was heard to also be "pounding the wall, uttering vulgarities" toward Resident #1 in earshot of the facility staff outside the room. Director #2 knocked on the door and the noise stopped. Director #2 reported that Visitor #1 opened the door then got in his face and began yelling profanity.

E. On 12/13/11 at 3:35 pm during interview with Caregiver #1, she reported that she had witnessed Visitor #1's outbursts projected on a non-family member, Resident #2, whose behaviors include looking for [redacted] asking for [redacted] and wandering in that pursuit throughout the unit. Caregiver #1 reported that she witnessed Visitor #1 yelling at Resident #2 to get out of Resident #1's room twice in the same evening.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 5796 | A. BUILDING: _____ B. WING _____ | C 12/19/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINGSTON RESIDENCE OF SANTA FE | 2400 LEGACY COURT SANTA FE, NM 87507 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) | D 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 6<br><br>F. Review of incident report dated 11/11/11 drafted by Caregiver #2, read that, "Around 8 PM Resident #2 barged into Resident #1's room and was yelling at Resident #1 and Visitor #1. Visitor #1 escorted Resident #2 out of the room by [redacted] arms and told [redacted] to stay out. Visitor #1 chased Resident #2 out of the room and grabbed Resident #2 by the shoulders and told [redacted] 'How many times have I told you to stay out of here?'."<br><br>G. On 12/12/11 at 2:00 pm during an interview with the Administrator, she acknowledged that the situation with Visitor #1 is ongoing and has not yet been resolved. | A 033 | | |