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 07/05/2023

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

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A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 07/05/23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities for Adults. Census (59) Complaint Intake NM67420 was investigated with deficiencies cited. Complaint Intake NM58347 was investigated with no deficiencies cited. Abbreviations: Direct Care Staff: DCS Director of Nursing: DON Resident: R Power of Attorney: POA	A 000	This plan of correction is prepared and executed because it is required for the provision of the state and federal regulations and not because Kingston Residence of Santa Fe agrees with the citations listed on this statement of deficiencies. Kingston Residence of Santa Fe maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. By submitting this plan of correction, Kingston Residence of Santa Fe does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standards of care, contract, obligation or positions and Kingston Residence of Santa Fe reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or preceding.	
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge;	A 020	The facility discharge notice has been corrected with the appeals statement removed from the document. Any future discharges will receive the updated notice. The notice will be given to the resident by the Executive Director, Director of Nursing, or Designee.	7/23/23

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A 020	Continued From page 1 (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other	A 020		

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A 020	Continued From page 2 material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident.	A 020		

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A 020	Continued From page 3 The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that	A 020		

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A 020	Continued From page 4 are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20.12 (a-e (i-iii)) Based on record review and interview, the facility failed to ensure for 1 (R #3) of 1 (R #3) resident that the discharge notice contained only information required by regulation, and did not include incorrect information regarding the residents right to appeal the discharge to the Department of Health. This deficient practice could likely result in the residents and/or their legal representatives to be misled to believe that they have the right to appeal the facility discharge with the New Mexico Department of Health. The findings are: A. Record review of the Discharge Notice issued to R #3 dated [redacted]/23, revealed the facility's Discharge Notice incorrectly included the following statement: "The resident has the right to appeal this transfer or discharge to the New Mexico Department of Health (NMDOH) if the	A 020		

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resident disagrees with the reason given for the transfer or discharge. The Appeal must be filed within 10 days of the dated of notice."

B. Record review of the 7 NMAC 8.2. Regulations for Assisted Living Facilities for Adults, revealed no regulation that allows for a resident and/or legal representative to appeal a discharge from an assisted living facility with the NMDOH.

C. On 06/21/23 at 9:47 am, during an interview with R #3's alternate POA, [redacted] stated:
1. [redacted] received some paperwork [redacted] could not remember exactly what paperwork it was) about the resident having the right to appeal [redacted] discharge with NMDOH.
2. [redacted] reached out to NMDOH (exact department unknown) and was told they did not know anything about an appeal process for a discharge.
3. [redacted] eventually found out the appeal process was through the Fair Hearings department with the New Mexico Human Services Department (for Nursing Home residents who receive Medicaid Benefits), not the New Mexico Department of Health, and reached out to them.

D. On 07/12/23 at 10:07 am, during an interview with the Administrator, she confirmed:
1. The facility's Discharge Notice included the following incorrect statement: "The resident has the right to appeal this transfer or discharge to the New Mexico Department of Health (NMDOH) if the resident disagrees with the reason given for the transfer or discharge. The Appeal must be filed within 10 days of the dated of notice."
2. She did not know the resident could not appeal their discharge with NMDOH and stated she found that information somewhere, but could not recall where.

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A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. 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. 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: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. 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. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs	A 033	Nursing staff will be re-educated on protecting the confidentiality of each resident's medical records. Resident's medical records will be stored in the resident's chart and remain in a secured area. A keypad lock will be added to each nurses station door to add an additional layer of security to protect resident's rmedical ecords. The definition of neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Residents have the right to sleep where they choose in their apartments. Those alternate choices, such as sleeping in a reclining chair, will be added to the resident's care plan. Nursing staff will offer to assist residents to bed nightly. Nursing staff will be re-educated on bedtime assistance protocol for residents. If a resident refuses to sleep in their bed, staff will notify the nurse-on-duty. The nurse will visit with the resident, confirm their choice, and document their decision	9/30/23

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and give advance written notice of any changes;
(4) provide residents with a safe and sanitary living environment;
(5) provide humane care for all residents;
(6) provide the right to privacy, including privacy during medical examinations, consultations and treatment;
(7) protect the confidentiality of the resident ' s medical record;
(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;
(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;
(10) prohibit the use of any and all physical and chemical restraints;
(11) ensure that residents:
(a) are free from physical and emotional abuse neglect and misappropriation/or exploitation;
(b) are free from financial abuse and 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

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A 033	Continued From page 8 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; and (q) are protected from unjustified room transfers or discharge. 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] This REQUIREMENT is not met as evidenced by:	A 033		

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A 033	Continued From page 9 7.8.2.33 D (7) (11) (a) Based on record review and interview, the facility failed to ensure: 1. They protected the confidentiality of the resident's record. 2. Residents were free from neglect. These deficient practices could likely affect the safety and welfare of the 59 (R #s 1-59) residents identified on the resident census provided by the Administrator on 06/21/23, if: 1. Resident records are viewed or accessed by unauthorized persons. 2. Residents are left in their chairs and not checked on throughout the night. The findings are: Regarding Resident confidentiality: A. On 06/22/23 at 11:00 am, during an interview with R #3 and [redacted] alternate POA, provided the surveyor with another resident's paperwork and indicated: 1. [redacted] found the paperwork on R #3's dresser a couple of days ago (06/20/23). 2. The paperwork appeared to belong to another resident living at the facility. 3. [redacted] does not know how the paperwork ended up on R #3's dresser or who put it there. B. Record review of the paperwork found by R #3's alternate POA, revealed it was a resident evaluation dated 01/09/23 for a former resident, R #6. C. On 06/22/23 at 12:58 pm, during an interview with the DON, she stated: 1. She did not know how R #6's resident	A 033		

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evaluation ended up on the dresser in R #3's room.
2. R #6's resident evaluation was dated over 6 months ago in January 2023, so she does not think any other staff would have been walking around with it to place it in R #3's room.
3. She confirmed the resident evaluation dated 01/09/23 belonged to R #6.

Regarding Resident neglect:

D. Record review of an email dated 06/16/23 from R #3's POA (Email forwarded to Licensing Authority) revealed that the resident was reported to have been left in [redacted] chair all night on 05/23/23 and no staff member ever came to put [redacted] to bed.

E. On 06/21/23 at 2:23 pm, during an interview with R #3, [redacted] confirmed that [redacted] was left in [redacted] chair all night on 05/23/23, and no staff member ever came to put [redacted] to bed.

F. On 06/23/23 at 9:00 am, during an interview with R #3's POA, she confirmed that R #3 was left in [redacted] chair all night on 05/23/23, and no staff member ever came to put [redacted] to bed.

G. On 06/26/23 at 11:38 am, during an interview with DCS #5, she confirmed:
1. On 05/23/23, she came in to work on a day shift, and found R #3 in already [redacted] chair in the morning after 7:00 am.
2. She questioned how R #3 would already be in [redacted] chair because [redacted] usually sleeps in late.
3. She questioned R #3 if staff ever put [redacted] to bed during the night, and R #3 told her no.
4. She believed the staff working the night of 05/22/23 and early morning hours of 05/23/23 were DCS #6 and DCS #7.

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A 033	Continued From page 11 H. Record review of the facility's staff schedule dated 05/22/23 to 05/23/23 for the 7:00 pm to 7:00 am shift revealed DCS #6 and DCS #7 were working for that shift. I. On 06/27/23 at 12:39 pm, during an interview with DCS #6, she stated: 1. She did not leave R #3 in [redacted] chair all night on 05/23/23. 2. [redacted] did not even work that night. J. On 06/27/23 at 1:04 pm, during an interview with DCS #7, she stated: 1. She did not leave R #3 in [redacted] chair all night on 05/23/23. 2. She was never instructed to check on R #3 once they put [redacted] to bed at night. K. Record review of R #3's Individual Service Plan (ISP) dated 10/15/22 revealed: 1. R #3 required periodic checks (laying eyes on them every couple of hours) 2. R #3 was dependent on staff for transfers.	A 033		