

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
8 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 09/25/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living Facilities for Adults. Resident Census: 91 Complaint Intake NM [REDACTED] was investigated with deficiencies cited. Complaint intake NM [REDACTED] and [REDACTED] were investigated with no deficiencies cited.	8 000			
8 032	8 NMAC 370.14.32 Reporting of Incidents A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within 24 hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be	8 032			

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]
11/5/25
Interim Executive Director

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
8 032	Continued From page 1 recorded on the state approved incident report form for the current year, pursuant to 8.370.9 NMAC; and (3) plans for further actions in response to the incident. [8.370.14.32 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.32 A (1) B REPORTING OF INCIDENTS A. The facility shall ensure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. B. The facility is responsible for conducting and documenting the investigation into all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. Based on record review and interview, the facility failed to report a [REDACTED] which involved a hospital transport and unwitnessed falls with injury for 3 (R#1, R#5 and R#6) of 3 (R#1, R#5 and R#6) residents that the facility was required to report incidents of suspected abuse that had or	8 032			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 032	Continued From page 2 could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority (LA) within twenty-four (24) hours and conduct an internal investigation and submit an investigation follow-up report to the LA within five (5) business days from when an incident occurred. This deficient practice has the potential for all residents identified in the census provided by the Administrator on 09/22/25, to be at risk of harm, illness, or injury if there is no oversight by the Licensing Authority. The findings are: A. Record review of R #5's initial incident report [REDACTED] submitted on [REDACTED] 25, revealed the following: 1. That on [REDACTED] 25, R#5 reported having an unwitnessed fall and complained of [REDACTED] which resulted in [REDACTED] transported to the Emergency Room via ambulance. 2. The initial Incident Report was submitted to the Health Care Authority on [REDACTED] /25 at 12:43pm. 3. There was not a 5-day follow-up to the Health Care Authority. B. Record review of R #6's initial incident report [REDACTED] submitted on [REDACTED] /25, revealed the following: 1. That on [REDACTED] /25, R#6 reported having an unwitnessed fall and hitting [REDACTED] which resulted in [REDACTED] transported to the Emergency Room for an evaluation. 2. The initial Incident Report was submitted to the Health Care Authority on [REDACTED] /25 at 1:09pm. 3. There was not a 5-day follow-up to the Health Care Authority. C. Record review of R #1's Morningstar Senior	8 032	Responses to the cited deficiencies do not constitute an admission or agreement by the community to the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law. 8.032 Reporting of Incidents A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. All Leaders at MorningStar of Santa Fe were trained on State Reportable Events on 10/15/25 B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. All incidents will be reviewed timely during morning clinical stand-up meetings to ensure that nothing reportable occurred.	10/15/25

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
8 032	Continued From page 3 Living Incident Report revealed the following: 1. That on [REDACTED] 25, R#1 was upset and [REDACTED] which resulted in 911 being called and R#1 being transported to the hospital. 2. There was no initial Incident Report submitted to the Health Care Authority or a 5-day follow up report. D. Record review of complaints and incident tracking system confirmed that the above incidents were not reported to the Licensing Authority (LA) within twenty-four (24) hours, nor was an internal investigation conducted and submitted to the LA within five (5) business days from when an incident occurred E. On 09/23/25 at 2:25 pm, during an interview, the Interim Administrator confirmed that initial incident report #'s [REDACTED] and [REDACTED] had not been followed up with an internal investigation conducted and submitted to the LA within five (5) business days. F. On 09/24/25 at 1:36 pm, during an interview, the Regional Vice President of Wellness confirmed the Morningstar Senior Living Incident Report in which R #1 was taken to the hospital should have been reported to the Health Care Authority.	8 032			
8 033	8 NMAC 370.14.33 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.	8 033			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 033	Continued From page 4 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 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;	8 033		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
8 033	Continued From page 5 (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 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 14 calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP;	8 033			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 033	Continued From page 6 (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. [8.370.14.33 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.33 D (4) Based on record review and interviews, the facility failed to provide residents with a safe living environment. This deficient practice has the potential to negatively affect all 30 residents', listed on the resident census provided by the Interim Administrator on 09/22/25, physical safety and well-being if a safe living environment is not adequately provided.	8 033		

Division of Health Improvement
STATE FORM

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
8 036	Continued From page 8 The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the "recommended daily dietary allowance" of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the "2005 USDA dietary guidelines for Americans." Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures: The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service: The facility shall: (a) serve at least three meals or their equivalent each day at regular times with no more than 16 hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one week cycle; (e) have special menus or meal items following guidelines from the resident's physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have	8 036			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 036	Continued From page 9 meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident's PCP within 48 hours if a resident consistently refuses to eat. (2) Staff in-service training: The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records: The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for 30 calendar days. C. Clean and sanitary conditions: All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation:	8 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 036	Continued From page 10 (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware: (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean	8 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
8 036	Continued From page 11 outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management: The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction. (1) The facility shall ensure that a minimum of a three calendar day supply of perishables and a five calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be 35 - 41 degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of 140 degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage	8 036			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
8 036	Continued From page 12 of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than 41 degrees fahrenheit; (b) the temperature for all hot foods is maintained at 140 degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk: (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as "additives" in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements: Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste	8 036			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
8 036	Continued From page 13 disposal, treatment facilities and private wells. [8.370.14.36 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.36 C (5) Based on observation and interviews, the facility failed to ensure cooks and food handlers wore hair nets or caps at all times when engaged in handling food, drink, utensils and equipment in accordance with the local health authority. This deficient practice could likely result in the 91 (R #s 1-91) residents identified on the census provided by the Administrator on 09/22/25, to be at risk of harm or contracting foodborne illnesses if food was not protected from biological hazards (harmful microorganisms or substances of biological origin that can cause foodborne illnesses when/if consumed) if kitchen staff are not wearing proper protective garments such as hair nets and caps. The findings are: A. On 09/25/25 at 8:36 am, during an observation of breakfast, Server #1 and #2 served breakfast to the residents without wearing a hairnet or cap. B. On 09/25/25 at 8:38 am, during an interview with the interim administrator, she confirmed that two kitchen staff (Server 1 & 2) were not wearing hairnets while serving food to residents. C. On 09/25/25 at 11:27 am, during an interview with the executive chef, he confirmed that two kitchen staff (Server 1 & 2) were not wearing hairnets while serving food to residents and stated there was no hairnet supply in the kitchen	8 036	8.036 Nutrition A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Executive Chef (EC) to ensure community has readily available supply of hairnets in the kitchen, 2. All culinary team members should be wearing hairnets or caps. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. All culinary team members will attend a food handler's training no later than 11/15/25. 2. Executive Chef along with ED shall ensure that all new hires in the future are trained with food handler's training before working in the kitchen.		11/15/25

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR ASSISTED LIVING AND MEMORY CAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2041 S PACHECO ST SANTA FE, NM 87505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
8 036	Continued From page 14 but would purchase hairnets for kitchen staff as soon as possible.	8 036			