February 12, 2025
Delivered via email.

Carol Andrade, Administrator
Sierra Vista
402 East Rodeo Road
Santa Fe, NM 87505

License # 5810

IMPORTANT NOTICE - PLEASE READ IMMEDIATELY

Dear Ms. Andrade:

On **January 27, 2025**, a Complaint Survey was conducted at Sierra Vista by the New Mexico Health Care Authority (HCA) to determine if your facility was in compliance with the New Mexico State Requirements for Assisted Living Facilities. This survey found that your facility was not in compliance with the participation requirements.

Plan of Correction (PoC)
Your PoC for the deficiencies listed on the Statement of Deficiencies **must be submitted within ten (10) calendar days** from your receipt of this form. Failure to submit an acceptable PoC may result in sanctions, including but not limited to civil monetary penalties, suspension, or non-renewal of the facility license [NMAC 8.370.14.12(B)(5)]. Include a completion date for each deficiency cited. Your PoC **shall**:

1. Address how all violations identified in the official statement of deficiencies will be corrected;

2. Address how the facility will monitor the corrective action and ensure ongoing compliance; and

3. Specify the date that the corrective action will be completed.

Please submit your PoC under the appropriate column on the enclosed Statement of Deficiencies. Address each deficiency and include the month, date and year of the expected completion date. **Sign, date, and indicate your title in the appropriate blocks on page 1 of the form.** Return the Statement of Deficiencies within ten (10) calendar days, with the PoCs to the DHI via fax, email or mail to the attention of:

Re Submitted 3/5/25

3/25/25

Review Office
PO Box H
Santa Fe, NM 87504
Fax: (505) 476-9048
HFLC.Review@hca.nm.gov

2/18/25

The Statement of Deficiencies must be printed as it was sent to you and put your PoCs on the original

Statement of Deficiencies. You are not permitted to alter the Statement of Deficiencies in any way.

Note: Failure to provide an acceptable plan of correction within the time period established and failure to correct deficiencies with the time period established may result in denial of an initial or renewal application or revocation/ suspension of the facility license, NMAC 8.370.14.13.

Informal Dispute Review (IDR)
You have an opportunity to contest any cited deficiency through an Informal Dispute Review (IDR) process, NMAC 8.370.14.12. If you choose to contest a cited deficiency, you must specify the exact deficiency being disputed along with an explanation of why you are disputing the deficiency **in writing**. All supporting evidence must be provided with the IDR request. **You will be required to submit one (1) copy of all supporting documents that have been properly redacted (with coded identifiers replacing actual resident and facility identifiers) and one (1) copy of all supporting documents unredacted, to the Review Office PO Box H, Santa Fe, NM 87504, (505) 476-9048,** by the tenth (10th) calendar day from receipt of this letter. **You are still required to submit your PoC within the timeframe.**

For the option to submit the IDR via email, please email your request to HFLC.Review@hca.nm.gov and we will send a secure email in which the IDR can be attached.

Failure to meet this timeframe waives your right to the IDR process. You will be advised in writing of the results related to the IDR.

An IDR request for any cited deficiency will not delay the imposition of the enforcement actions. If the deficiency is removed, a new statement of deficiencies will be issued to the facility.

If you have additional questions regarding this notice, please contact me at (505) 318-7799.

Sincerely,

Valerie Cordova, Bureau Chief
Licensed Oversight Bureau
Division of Health Improvement

Resubmitted again
3/25/25

Attachments: January 27, 2025, Health Statement of Deficiencies.
IDR Process

Please take a moment to complete an online survey regarding your experience with DHI. You can find this on Survey Monkey at the following link:

https://www.surveymonkey.com/r/DHI_Health_Facility_Customer_Satisfaction_Survey

Your responses are completely anonymous and will be used to improve our performance. We may periodically share the results of these surveys with relevant trade associations as well.

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5810	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA	402 EAST RODEO ROAD 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 01/27/25 for the state requirements of NMAC 8.370.14. Regulations for Assisted Living for Adults. Census: 24 Complaint Intake: NM#73041 NM#[redacted] and NM#[redacted] were investigated with deficiencies cited.	8 000		
8 020	8 NMAC 370.14.20 Admissions and Discharge The facility shall not admit or retain individuals that require 24 hour continuous nursing care, refer to Subsection U of 8.370.14.7 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	8 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5810	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA	402 EAST RODEO ROAD 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
8 020	Continued From page 1 (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. 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 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); The facility shall not admit or retain individuals that require 24 hour continuous nursing care, refer to Subsection U of 8.370.14.7 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	8 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5810	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA	402 EAST RODEO ROAD 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
8 020	Continued From page 2 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. 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	8 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5810	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA	402 EAST RODEO ROAD 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
8 020	Continued From page 3 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 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 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. [8.370.14.20 NMAC - N, 7/1/2024]	8 020	3/25/25 ① Action to correct: Initial evaluation/assessment was documented 2 days after move in not 15 days prior to move in as required by regulation ② How facility will identify Potential deficient practice going forward is Should an emergency situation as in this example evaluation/assessment will be completed day of move in. ③ New measures/changes implemented are the facility has integrated it's pre-admission assessment process into our digital operating System Requiring Completion prior to move in. ④ Facility will monitor New measures through Automated work flows built within System ensuring this is completed within regulatory time lines. All implementation of New measures as of March 1, 2025 And will be monitored by Administrator of facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5810	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA	402 EAST RODEO ROAD 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
8 020	Continued From page 4 This REQUIREMENT is not met as evidenced by: 8.370.14.20 C 1 (a-c) 2 (a) Based on record review and interview, the facility failed to ensure for 1 (R #1) of 1 (R #1) resident who receives hospice services and had multiple falls, that the team jointly met to determined if the resident could remain at the facility, and that all of the team members signed the admission agreement. This deficient practice could likely cause harm to resident if their Power of Attorney (POA) and or Decision Maker does not sign the team approval that is to be documented in the resident file. The findings are: A. Record review of R #1's (date of admission [redacted] nitial evaluation dated [redacted] revealed R #1 a score as a significant [redacted] [redacted] B. Record review of R #1's [redacted] dated [redacted] evealed R #1 required the use of [redacted] C. Record review of R #1's progress notes revealed the following: 1. R #1 [redacted] prior to a team member meeting that was held on 02/07/24. a. [redacted] occurred on [redacted] b [redacted] occurred on [redacted]	8 020	2/18/25 Historically Staff has made decisions on move in's. However after review we will from here forward Request POA's and Hospice (if applies) to also sign approval of move ins. A 0020 3/5/25 Staff will moving forward include family, staff and any Hospice staff in IDT meetings and sign the retention plan Staff will meet regularly to discuss elders who may need an updated ISP or retention plan Facility has a safety Committee who will oversee Incident Reports and advise what elder needs a retention Plan 8YP011 See Attached memo for Action plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5810	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA	402 EAST RODEO ROAD 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
8 020	Continued From page 5 c [redacted] occurred on [redacted] 2. The facility did not jointly approve in writing that the resident was deemed fit to be retained at the facility despite amount of falls at team member resident status update meeting on 02/07/24. D. On 01/27/25 at 1:03 pm during an interview with the executive director, he acknowledged the following: 1. A family conference was held on [redacted] for R #1 regarding [redacted] for the resident including: a. Staff documented that R #1 was [redacted] b. R #1 [redacted] to the facility [redacted] and had supplemental [redacted] c. R #1 continued to exhibit [redacted] d. R #1 refused [redacted] E. On 01/27/25 at 1:03 pm during an interview with the executive director, he acknowledged the facility did not create or sign any documentation to allow R #1 to remain in the facility after meeting with the team to discuss [redacted]	8 020	2/18/25 ISP's previously had indicated Elder's need for fall monitoring, feeding assistance and oxygen use so a new ISP was not thought to be needed but after review facility has updated procedure to update ISP with additional information as the need presents and an evaluation between POA, Hospice or physician if Aging in Place Applies.	
8 025	8 NMAC 370.14.25 Resident Evaluation A. A resident evaluation shall be completed by an appropriate staff member within 15 days prior	8 025	A0025 3/5/25 Careplans will be updated if elder identified as falls risk. Safety Committee will bring to attention by monitoring Incident Reports. Currently elder identified moved to another facility. Memo issued and signed regarding procedures and protocols moving forward.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5810	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA	402 EAST RODEO ROAD 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
8 025	Continued From page 6 to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident's functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six months or when there is a significant change in the resident's health status. C. The resident's evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc.; (3) communication and hearing; ability to communicate needs and understand instructions, etc.; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history	8 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5810	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA	402 EAST RODEO ROAD 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
8 025	Continued From page 7 and physical examination and an evaluation report by a physician or a physician extender within six months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six months or when a significant change in health status occurs. [8.370.14.25 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.25 A Based on record review and interview, the facility failed to ensure for 1 (R #1) of 1 (R #1) residents whose resident file was reviewed for compliance included an Evaluation/Assessment that was completed within 15-days prior to admission. This deficient practice could likely result in the residents not receiving appropriate care and services upon admission and that the Direct Care Staff (DCS) will not be aware of what the resident's needs are. The findings are: A. Record review of R #1's resident file (admitted o[redacted] revealed the record contained an initial evaluation/assessment that was dated on [redacted] which is not completed before the fiften (15) days prior to admission. B. On 01/27/25 at 01:03 pm, during an interview with the Executive Director, they acknowledged	8 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5810	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA	402 EAST RODEO ROAD 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
8 025	Continued From page 8 that evaluation/assessment was completed on [redacted] for R #1.	8 025		
8 026	8 NMAC 370.14.26 Individual Service Plan An ISP shall be developed and implemented within 10 calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six months or when there is a significant change in the resident's health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility's determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when	8 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5810	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA	402 EAST RODEO ROAD 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
8 026	Continued From page 9 indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [8.370.14.26 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.26 A Based on record review and interview, the facility failed to revise the individual service plan, (ISP: a comprehensive plan, developed by the interdisciplinary team that identifies all treatment, habilitation and services for a resident) for 1 (R #1) of 1 (R #1) to include interventions for falls. This deficient practice could likely result in the ISP not reflecting residents current goals and care needs preventing residents from gaining and/or maintaining their highest practicable level of well-being. The findings are: The findings are: A. Record review of R #1's Face sheet revealed R #1 was admitted to the facility on [redacted] with a diagnosis of [redacted] B. Record review of R #1's Evaluation dated [redacted] revealed R #1 was identified [redacted] C. Record review of R #1's initial ISP dated [redacted] did not include fall interventions. D. Record review of R #1's progress notes	8 026	2/18/25 ISP did get revised by staff but did not include Interdisciplinary team and from here forward will ensure POA and outside agency (Hospice) or physician to be included A 0026 3/5/25 Safety Committee will monitor frequency of falls and identify if an elder needs a new care plan with fall prevention and or a retention plan with family, staff and any other outside agency or physician as required protocol implemented as of 3/1/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5810	A. BUILDING: _____ B. WING _____	C 01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA	402 EAST RODEO ROAD 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
8 026	Continued From page 10 revealed R #1 sustained six (6) falls between [redacted] 1. [redacted] 2. 3. 4. 5. 6. E. Record review of R #1's resident file revealed that the ISP was not updated to reflect fall interventions after each fall between [redacted] and [redacted] F. On 01/27/25 at 1:03 pm during an interview, the Executive Director acknowledged R #1's ISP dated [redacted] did not include fall interventions and was not updated after each fall between [redacted]	8 026	2/10/25 Our current ISP did reflect fall interventions and there were no changes that could have been reflected in ISP inorder to update as there already were spot checks, Alarms, monitoring, medication interventions and a family conference which all indicated that Elder's needs were being realistically met after each fall.	