STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4032	A. BUILDING: _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY AT SANTA FE	3 AVENIDA ALDEA SANTA FE, NM 87507

(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 06/27/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living Facilities for Adults. Resident Census: 75 Complaint Intake NM[redacted] was investigated and deficiencies were cited.	8 000	Preparation and/or execution of this plan of correction does not constitute admission of agreement of the truth of the allegations set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely as it is required by state and federal law. Please accept this Plan of Correction as our credible allegation of compliance	
8 016	8 NMAC 370.14.16 Staff Qualifications A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a 40-mile radius may have one full-time administrator. The administrator shall: (1) be at least 21 years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico caregivers criminal history screening act, 8.370.5 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three notarized letters of reference from persons unrelated to the applicant; and	8 016		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Karen L Powers 8/14/25 Executive Director

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8 016	Continued From page 1 (9) comply with the pre-employment requirements pursuant to the employee abuse registry, 8.370.8 NMAC. B. Direct care staff: (1) shall be at least 16 years of age; (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 8.370.8 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to incident reporting, intake processing and training requirements, 8.370.9 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver's license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the caregivers criminal history screening requirements, 8.370.5 NMAC, shall provide current (within the last 6 months) proof of the caregiver's criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the caregivers criminal history screening requirements, 8.370.5 NMAC.	8 016		

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8 016	Continued From page 2 [8.370.14.16 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.16. A (3) (9) Refer to 8.370.8 EMPLOYEE ABUSE REGISTRY 8.370.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In	8 016	By August 7, 2025, the Executive Director, BOD, and/or designees will audit all personnel files to ensure that required documentation, including reference checks, have been completed as required. For any personnel files determined to be lacking required documentation, such documentation will be obtained to complete the file. The Executive Director and/or BOD will audit personnel files on a periodic basis to ensure personnel files contain required documentation. A Universal Background check was run for the MCRSA which reported a clear record on July 18, 2025 On July 21, 2025, Legacy at Santa Fe received the clearance from New Mexico Caregivers Criminal History Screening Program (CCHSP) for authorization to submit and print from the CCHPS data base fingerprint results, background check results, and Employee Abuse registry results. For all new hires, the Business Office Manager will adhere to New Mexico Health Care Authority Guidelines reporting guidelines. ensure personnel files contain required documentation prior to employee start date. Completion Date: August 15, 2025	

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8 016	Continued From page 3 making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an	8 016		

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8 016	Continued From page 4 employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [8.370.8.8 NMAC - N, 07/01/2024] 8.370.5.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 8.370.5.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. 4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to	8 016		

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8 016	Continued From page 5 support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 8.370.5.7 NMAC, no later than twenty (20) calendar days from the first day of employment or	8 016		

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8 016	Continued From page 6 effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility failed to provide employee background clearance documentation by the Employee Abuse Registry (EAR) prior to hire for 1 out of 6 staff (particularly Memory Care Resident Service Assistant (MCRSA). These deficient practices could likely result in residents to be at risk of harm or abuse if residents are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents, and may be a convicted felon. The findings are:	8 016		

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8 016	Continued From page 7 A. Record review of the MCRSA employee file, date of hire 05/29/23, revealed the facility failed to provide documentation that the MCRSA received a clearance from the EAR prior to hire and prior to providing direct care to residents. B. On 6/27/25 at 1:45 pm, an interview with the Executive Director revealed the facility had installed a new computer database that caused a disruption in accessing the NM Licensing Authority background check portal, therefore, the facility was unable to provide documented proof a pre-hire background check was conducted (with a clearance) for the MCRSA. The facility's inability to access the background check portal places the safety of all residents at risk if new hires have not been thoroughly screened prior to working with residents.	8 016		
8 021	8 NMAC 370.14.21 Resident Records A. Record contents: A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 8.370.14.20 NMAC; (2) the resident evaluation form, that is to be completed within 15 days prior to admission and updated at a minimum of every six months; (3) the current ISP, that is to be completed within 10 calendar days of admission and updated at a minimum of every six months;	8 021		

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8 021	Continued From page 8 (4) the physical examination report; the physical examination report shall have been completed within the past six months, by a primary care physician, a nurse practitioner or a physician's assistant and shall be on file in the resident's record within 10 days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP;	8 021		

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8 021	Continued From page 9 (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 8.370.14.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance: (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction	8 021		

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8 021	Continued From page 10 and unauthorized use for a period of not less than five years from the date of discharge and readily available within 24 hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [8.370.14.21 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.21 B(3) Based on record review and interview the facility failed to ensure that non-current resident records were maintained by the facility against loss, destruction and unauthorized use for a period of not less than five years from the date of discharge and readily available within 24 hours of request. This deficient practice could likely result in the resident recorded history being unavailable to the licensing authority at the time of request. The findings are: A. Record request of R #3's Medication Administration Record (MAR) (May thru July 2024) and doctor's order for a prescribed medication [redacted] on 07/02/25, revealed R #3's MAR and doctor's order were not on premises, thereby, prompting the executive director to contact the facility corporate office (out-of-state) to locate the documents. B. On 07/08/25 at 9:11 am, during a phone interview, the Administrator confirmed R #3's MAR and doctor's order for prescribed medication	8 021	Executive Director, Business Office Manager or designee will audit discharged resident records to ensure all have been properly stored. Discharged resident records will be maintained onsite or electronically by the community for a minimum of 5 years from the date of discharge. Records will be available upon request within 24 hours. The Executive Director, Business Office Manager or designee will store discharged records within 48-72 hours from the date of discharge. The BOD and/or designee will perform an audit monthly for 3 months and/or until compliance is sustained to ensure discharged records have been properly stored in its entirety. Documentation of the audit will be maintained by the Business office Manager. Completion Date: August 15, 2025	

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8 021	Continued From page 11 were not available due to corporate's inability to access a previously utilized computer database (Yardy).	8 021		
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 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]	8 032		

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8 032	Continued From page 12 This REQUIREMENT is not met as evidenced by: 8.370.14.32 A (1) (2), B (1) REPORTING OF INCIDENTS: A. The facility shall ensure (to make certain that something shall occur or be the case) 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. (3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the bureau incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. 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 ensure for 1 (R #3) of 1 (R #3) the the Licensing Authority (LA) was notified within twenty-four (24) hours, along with a five (5) business day investigation follow-up report to the the Licensing Authority (LA) was completed. This deficient practice could impede (delay or prevent) regulatory oversight and hinder (create difficulties resulting in delay) the identification of	8 032	• Executive Director and/or designee will audit all current self-reports by August 15, 2025 to assure all reports have been completed per NMAC reporting guidelines. Any unsubmitted 5-day follow ups, will be submitted immediately. • Regional Team will re-train Executive Director or designee on NMAC reporting guidelines and PSL reporting guidelines related to reporting events. • Regional Team will review, and audit reports made by community staff to ensure initial self-reports are submitted to NMAC within the time identified by NMAC reporting guidelines. Regional Team will review, and audit self-reports submitted to ensure the 5-day follow up investigation report is completed then submitted within the 5-day follow-up period as required by NMAC. • Executive Director and/or designee will complete and submit the 5-day follow up as required by NMAC reporting guidelines. Completion Date: August 15, 2025	

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	4032	A. BUILDING: _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY AT SANTA FE	3 AVENIDA ALDEA SANTA FE, NM 87507

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8 032	Continued From page 13 care trends or patterns that may affect resident outcomes. The findings are: A. 1. Record review of R #3's resident progress notes revealed the following: a. On [redacted]/24, the resident had an unwitnessed fall at the facility resulting in a [redacted] requiring EMT's to transport the resident to [redacted] hospital. b. On [redacted]/25, a progress note described the resident had an unwitnessed fall, the resident refused EMT transport, but the POA took the resident to the hospital herself. 2. R #3's Internal (facility-created) Incident Reports revealed unwitnessed falls on: a. [redacted]/24 at 4:30 pm that resulted in the resident sustaining a [redacted] b. [redacted]/24 at 3:00 am that resulted in the resident sustaining a [redacted] and the resident being transported to the local hospital for evaluation. c. [redacted]/24 at 10:15 am with no documented injuries. d. [redacted]24 at 8:30 am that resulted in an ambulance being called resulting in emergency medical staff examining the resident at the facility. B. Record Review of R# 3's resident file revealed no licensing authority incident reports present that addressed consecutive falls resulting in hospital visits. C. On 06/25/25 at 9:48 am, during an interview with the Exective Director, confirmation was recieved R#3's had no licensing authority incident reports concerning R#3's consecutive falls that resulted in hospital visits.	8 032		

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8 032	Continued From page 14 D. On 06/26/25 at 12:21 pm, during an interview with the corporate Licensed Vocational nurse , (normally works remotely from the Houston corporate office), stated the medication technicians or shift leads are responsible to initiate incident reports and give the reports to the Health & Wellness Director or the Executive Director and either one is responsible to submit a report to LA. She stated she is familiar how to access the LA portal and relies on staff to notify her (via phone call or email) so she can submit LA reports, if needed, until the facility secures a permanent, on-site Wellness Director. The Licensed Vocational nurse had no incident report record for R# 3. E. On 06/27/25 at 1:20 pm, during an interview with the Memory Care Coordinator revealed she was unaware R# 3 had falls that required hospital visits. She stated if falls occur, facility staff who witnessed or found the resident are supposed to create an internal incident report and notify the facility nurse (currently there is no on-site nurse-only a remote nurse at the corporate office in Houston, TX), then the nurse is responsible to submit the incident report to the Licensing Authority. G. On 06/27/25 at 10:51 am, during an interview with the Memory Care Resident Service Assistant, she stated she was not aware of what situations constitute notifying the Licensing Authority (LA). She provided a copy of an internal incident report but does not know how to access the LA portal to submit an incident report. H. On 07/01/25, Record review of R #3's medical records from [redacted] hospital (November [redacted]24 to [redacted]25), revealed the resident went to the	8 032		

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8 032	Continued From page 15 hospital after falling at the facility on the following dates: 1. [redacted]/24, resident fell while eloping from facility. 2. [redacted]/24, resident fell while walking to the restroom-[redacted] 3. [redacted]/25, resident had witnessed fall at facility. 4. [redacted]/25, resident had multiple falls, [redacted] 5. [redacted]/25, resident fell causing [redacted] I. On 07/01/25, a Licensing Authority database search revealed the facility failed to submit incident reports when R#3 fell on several occasions at the facility resulting in hospital visits on [redacted]24, [redacted]/24, [redacted]/25, [redacted]/25 and [redacted]/25.	8 032		
8 034	8 NMAC 370.14.34 Custodial Drug Permits A facility with two or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee.	8 034		

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8 034	Continued From page 16 (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident's name; (d) the prescriber's name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a	8 034		

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8 034	Continued From page 17 physician's order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist: The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within 72 hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 8.370.14 NMAC. [8.370.14.34 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by:	8 034		

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8 034	Continued From page 18 8.370.14.34 A Based on observation and interview, the facility failed to ensure for 1 (R #4) of 4 (R #s 1 through 4) residents that their medications were labeled with the correct last name (in accordance with state and federal laws). This deficient could likely result in staff giving residents the wrong medications or residents missing their prescribed medications if the correct last name is not labeled on the resident's medication. The findings are: A. On 06/24/25 at 9:40 am during Record review of R#4s 06/2025 Medication Administration records (MAR) revealed that R#4s physician's were using two (2) different last names when prescribing R#4s medications including: 1. Last name #1, the name used on the residents facility residential records and government issued health insurance card and, 2. Last name #2, the name used on the residents passport identification card. B. On 06/24/25 at 11:40 am during observation of R#4s medication in the facility medication cart revealed the residents medication bubble packs were were labeled with (2) two last names including: 1. Medication bubble packs with the residents last name #1, the name used on R#4s government issued health insurance card: a. [redacted] b. [redacted] c. [redacted]	8 034	HWD/ and or Designee completed an audit to ensure all residents identifiers are correct according to community residential agreement and government issued insurance card. HWD/ and or designee will provide pharmacy with copies of resident government issued ID/insurance card for identification verification and labeling of all medications. Community and pharmacy records will indicate legal name of resident on file. Staff re-education has been completed on medication management for appropriate identification verification to include not amending pharmacy labels. To ensure ongoing compliance all new hire medication techs will be trained on the medication management process/verification of resident identifier and if there are any breaks in the process, re-training will be provided immediately by the HWD and/or designee. HWD and/or designee will verify that resident identification, medication labels and resident record identifiers align upon admission to the community. Resident #4: The physician was notified on July 2, 2025, to resend prescriptions to the pharmacy with the last name indicated on the insurance card on file with the pharmacy and community.	

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8 034	Continued From page 19 [redacted] d. [redacted] e. [redacted] f. [redacted] 2. Medication bubble packs with the residents last name #2, the name used on R#4s passport identification card: a. [redacted] b. [redacted] c. [redacted] d. [redacted] e. [redacted] C. On 07/01/25 during an interview with the facilities former consulting pharmacist, the pharmacist confirmed that R#4s last name on medications in the facility should match the name on the residents facility Residential Agreement and government issued health insurance card.	8 034	Continued from previous page. Pharmacy provided new labels noted for the following medications: [redacted] Completion Date: July 21, 2025	
8 035	8 NMAC 370.14.35 Medication Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or	8 035		

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8 035	Continued From page 20 discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator's designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication: (1) Physician or physician extender's orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments.	8 035		

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8 035	Continued From page 21 E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR): For residents who are not independent and require assistance with self-administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order;	8 035		

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8 035	Continued From page 22 (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given	8 035		

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8 035	Continued From page 23 immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC. [8.370.14.35 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.35 G (14) Based on record review and interview, the facility failed to ensure for R #3 of 4 (R #1 through R #4) residents whose Resident Medication Administration Records (MARs) were reviewed that: 1. Resident Medication Administration Records (MARs) were available for review at the facility. 2. Blood pressure was being taken per physician's order. These deficient practices could likely result in the residents being at risk for medication errors if the MAR is unavailable and blood pressure being too low if blood pressure was not being taken as ordered. The findings are: D. On 07/02/25 at 12:05 pm a record request for R[redacted] April through July of 2024 Medication Administration records revealed the records were not available and were no longer on file at the facility.	8 035		

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8 035	Continued From page 24 E. On 07/08/25 at 9:11 am the Administrator/Executive Director confirmed that R [redacted] April thru July of 2024 Medication Administration records (MARs) could not be accessed by the facility or the facility's corporate office and were not available for review. She stated the records were lost when the facility switched their electronic MAR system. F. Record review of physician's order's for R #3 revealed: 1. [redacted] 2. [redacted] G. Record review of blood pressure logs for R[redacted] revealed blood pressure was not being recorded from 04/17/24 through 06/01/24 and: 1. 06/02/24 blood pressure was only taken once at 9:05 am. 2. 06/03/24 blood pressure was only taken once at 1:31 pm. 3. 06/04/24 blood pressure was only taken once at 8:48 am. 4. 06/05/24 blood pressure was only taken once at 9:06 am. 5. 06/06/24 blood pressure was only taken twice, once at 8:04 am and once at 1:07 pm. 6. 06/08/24 blood pressure was only taken once at 2:18 pm. 7. 06/09/24 blood pressure was only taken once at 8:02 am. 8. 06/11/24 blood pressure was only taken once at 8:05 am. 9. 06/13/24 blood pressure was only taken once at 1:52 pm.	8 035	Medication Administration: HWD/ and or designee audited current orders to ensure medication records are accurately reflect orders with blood pressure checks prescribed via physician orders. (Completed July, 21, 2025) HWD/ and or designee will be re-trained now on process to review all orders received from medical providers entered on the MAR for accuracy. If there is a break in the process, re-training will be provided immediately. To ensure ongoing compliance the HWD and/or designee will perform a monthly vital sign order review and document completion of the review on the resident's medication administration record. The Executive Director and/or designee will perform a routine audit of the MAR to ensure compliance. Resident [redacted] Moved Out of Community Completion Date: August 15, 2025	

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(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
8 035	Continued From page 25 10. 06/17/24 blood pressure was only taken once at 8:25 am. 11. 06/18/24 blood pressure was only taken once at 8:19 am. 12. 06/20/24 blood pressure was only taken twice, once at 8:24 am and once at 1:11 pm. 13. 06/22/24 blood pressure was only taken once at 8:24 am. 14. 06/23/24 blood pressure was only taken twice, once at 8:26 am and once at 1:56 pm. 15. 06/24/24 blood pressure was only taken once at 8:21 am. 16. 06/29/24 blood pressure was only taken once at 1:12 pm. 17. 06/30/24 blood pressure was only taken twice, once at 8:41 am and once at 1:36 pm. 18. 07/02/24 blood pressure was only taken once at 8:23 am. 19. 07/03/24 blood pressure was only taken twice, once at 8:41 am and once at 12:00 pm. 20. 07/10/24 blood pressure was only taken twice, once at 8:21 am and once at 1:17 pm. 21. 0711/24 blood pressure was only taken twice, once at 8:58 am and once at 1:14 pm. 22. 07/18/24 blood pressure was only taken once at 1:24 pm. 23. 07/20/24 blood pressure was only taken twice, once at 8:25 am and once at 1:05 pm. 24. 07/23/24 blood pressure was only taken once at 1:50 pm. 25. 07/24/24 blood pressure was only taken twice, once at 8:34 am and once at 2:33 pm. 26. 07/29/24 blood pressure was only taken once at 1:04 pm. 27. 08/01/24 blood pressure was only taken once at 11:31 am. 28. 08/07/24 blood pressure was only taken once at 9:19 am. 29. 11/08/24 blood pressure was only taken once at 9:08 am.	8 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4032	A. BUILDING: _____ B. WING _____	C 06/27/2025

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THE LEGACY AT SANTA FE	3 AVENIDA ALDEA SANTA FE, NM 87507

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8 035	Continued From page 26 F. On 07/08/25 at 9:11 am the Administrator/Executive Director confirmed that R [redacted] blood pressure logs for 04/17/24 - 06/01/24 were not recorded and his blood pressure was not taken 3 times daily every day per the physician order.	8 035		
8 038	8 NMAC 370.14.38 Housekeeping Services The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [8.370.14.38 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: NMAC 8.370.14.38	8 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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8 038	Continued From page 27 Based on observation and interview, the facility failed to ensure cleaning supplies and hazardous chemicals (Any chemical that presents as a health hazard or can cause physical harm) were stored in secured areas and were not accessible to residents. This deficient practice can likely result in residents to be at risk of harm, illness, or injury if the residents were to spill or ingest (take food, liquids, or other substances in the body by swallowing or absorbing it) cleaning supplies and/or hazardous chemicals. The findings are: A. On 06/23/25 at 11:00 am, during observation of the first floor of the building, the room identified as the "Resident Gym" was observed to have a desk drawer that was unsecured and contained one (1) 16-ounce bottle of Ear-Piercing Care Solution. B. On 06/23/25 at 11:30 am, during observation of the building, the room identified as the "Collection Room" was observed unsecured, open, and containing the following unsecured hazardous chemicals and waste: 1. One (1) 40- gallon red Medical Waste container with an unsecured lid and trash on its lid. 2. One (1) 3- gallon yellow mop bucket containing an unknown liquid. 3. One (1) black and white spray bottle filled with an unknown liquid/chemical. 4. Six (6) unsecured 5-gallon buckets of cleaning solutions including bleach and laundry detergents. 5. One (1) rectangular trash container with an unsecured plastic bag inside of it , no lid, and with	8 038	The Executive Director and/or designee will establish a protocol with the housekeeping team by August 8, 2025. Routine door checks will be performed by community staff to ensure doors are properly secured. Documentation of door checks will be maintained electronically. Staff will be re-trained on proper disposal, use of chemicals and maintenance of storage areas. Executive Director and/or designee will routinely audit compliance and provide immediate re-training if any breaks of the process occur. Weekly, unsecured drawers and shelves in the accessory furniture located throughout the community will be checked for unsecured chemicals that are deemed hazardous and need to be secured in a locked cabinet or closet. Continued on the next page	

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8 038	Continued From page 28 exposed trash. C. On 06/23/25 at 11:31 am, during observation of the building, the Dining Room-server station cabinets were observed to have a bottom cabinet that contained One (1) 32-ounce bottle of unsecured spray disinfectant. D. On 06/23/25 at 11:39 am, during observation of the Second Floor Activities/Craft room the room was observed to be unsecured and contained unsecured chemicals that were accessible to residents and included: 1. One (1) unsecured black wagon that contained: a. (2) 7.623-ounce bottle of white glue. b. (1) quart size can of paint. 2. One (1) Unlocked storage cabinet that contained: a. (2) 7.623-ounce bottles of clear craft glue. b. (1) 24-ounce spray blue bottle of white board cleaning spray. c. (1) 3-ounce bottle of All-purpose adhesive glue. d. (1) 32-ounce bottle of dry erase spray. 3. One (1) unsecured drawer under the countertop that contained (1) 24-ounce spray bottle of white board cleaning spray. F. On 06/23/25 at 12:20 pm, during an interview, the Executive Director confirmed the unsecured hazardous chemicals findings.	8 038	Provide a checklist of all accessory furniture drawers and shelves that should be examined on a weekly basis. The checklist will be submitted every Friday to the Maintenance Director and/or designee. By July 30 all dining team staff will be re-educated on hazardous kitchen chemicals and proper storage. Storage space identified for Quat 4 and disinfectant sprays behind kitchen doors and in secure cabinets in kitchen area. Completion date: August 15, 2025	