Concise Explanatory Statement For Rulemaking Adoption:

Findings required for rulemaking adoption:

Findings MUST include:

- Reasons for adopting rule, including any findings otherwise required by law of the agency, and a summary of any independent analysis done by the agency;

- Reasons for any change between the published proposed rule and the final rule; and

- Reasons for not accepting substantive arguments made through public comment.

The concise explanatory statement is attached.

Issuing authority (If delegated, authority letter must be on file with ALD):
Name:

Katrina Hotrum-Lopez

Check if authority has been delegated

Title:

ALTSD Cabinet Secretary

Signature: **(BLACK ink only OR Digital Signature)**

Katrina Hotrum-Lopez

Date signed:

July 12, 2022

NEW MEXICO AGING & LONG-TERM SERVICES DEPARTMENT

Michelle Lujan Grisham, Governor
Katrina Hotrum-Lopez, Cabinet Secretary

CONCISE EXPLANATORY STATEMENT

The Aging and Long-Term Services Department hereby adopts the repeal and replacement of 9.2.24 NMAC. Part 24 of Title 9, Chapter 2, shall be named THE ADMINISTRATION OF THE CONTINUING CARE ACT.

(1) Statutory Authority for Rule Promulgation:

This rule is adopted by authority of the Cabinet Secretary pursuant to Subsection E of Section 9-23-6 NMSA 1978, by authority of the Continuing Care Act, Sections 24-17-1 through 24-17-18 NMSA 1978, and by authority of the Aging and Long-Term Services Department pursuant to Subsection B of Section 28-4-6 NMSA 1978.

(2) Effective Date of Rule:

The effective date of the rule is the date of publication in the New Mexico Register.

(3) Date of Adoption of Rule:

The date of adoption of the rule is the date the Concise Explanatory Statement is signed by the Cabinet Secretary.

(4) Date of Meeting at which Agency Voted to Approve Adoption of Rule if the Agency is a Board or Commission:

The Agency is not a Board or Commission, so this is not applicable to the adoption of this rule.

(5) Reasons for Adopting the Rule:

The purpose of the repeal and replacement of the rule is to comply with amendments made to the Continuing Care Act, Sections 24-17-1 through 24-17-18 NMSA 1978. The rule is no longer limited to rate and fee increases by continuing care communities, but now provides additional guidance on the administration of the Continuing Care Act in accordance with New Mexico law. Pursuant to Subsection B of Section 24-17-2 NMSA 1978, "[t]he purpose of the Continuing Care Act is to provide for disclosure and the inclusion of certain information in continuing care contracts in order that residents may make informed decisions concerning continuing care," "provide protection for residents," and "ensure the solvency of communities."

(6) Reasons for Any Change Between the Published Rule and the Final Rule:

Subsection D of 9.2.24.8:
The Department received comments from two individuals requesting that the mathematical computation that supports rate increases—accurate to one-hundredth of a percent—be provided to residents because vague

explanations supporting rate increases are subjective and defy accurate evaluation. The Department agrees that the community should be transparent in this manner and has added this requirement to Subsection D of 9.2.24.8. It now states the following: "Additionally, the community shall supply the mathematical calculations used to support a rate or fee increase to at least two decimal places."

Subsection A of 9.2.24.16:

The Department received a comment requesting that the Department require a standard financial reporting form in the disclosure statement so that financial information is presented in an understandable way. The commenter provided a sample form as an example. The Department believes this is a reasonable request and would like the flexibility to implement a standard disclosure statement submission form in the future. To that end, the Department has added the following language to Paragraph (1) of Subsection A of 9.2.24.16: "In the event a fillable template is created by ALTSD for submission of disclosure statements, providers shall use the ALTSD template. ALTSD shall notify providers when a template is available for use and provide instructions for accessing it."

The Department received a comment requesting that it revisit "economic necessity" and the situation where funds may be lacking because a sole member owner invested in other properties and made the community part of the obligated group of non-profits responsible for covering any of the subsidiary losses. The commenter believes the community should be protected should this occur. While the Department cannot lawfully prohibit this practice, the Department believes, in the interest of transparency, that this type of action should be disclosed to residents. Therefore, in Paragraph (2) of Subsection A of 9.2.24.16, the Department has added this type of disclosure to the disclosure statement requirements. The new language states the following: "The disclosure statement shall include the extent of any guarantee or cross collateralization if a provider guarantees the debt of another legal entity or otherwise cross collateralizes its assets for the benefit of another legal entity." This information should be reflected in the audited financial statement and audit report required under the Act, but due to concerns raised by the comment, the Department thought it best to highlight it under the disclosure statement requirements in the rule.

The amendments made to the rule after publication fall within the scope of the rulemaking proceeding under Subsection C of 1.24.25.14 NMAC, and are within the scope and purpose of the Continuing Care Act.

(7) Reasons for Not Accepting Substantive Arguments Made Through Public Comment:

Commenters raised several suggestions that the Department appreciated, but declined to incorporate, into the new rule. Explanations for the Department's decisions are provided below.

Rate and Fee Increases

Subsection A of 9.2.24.8

The Department received two comments requesting a requirement that monthly fees be changed no more frequently than annually. The Department does not have statutory authority to prohibit fee changes in this manner. The language in the rule regarding rate and fee increases tracks the language of Paragraph (11) of Subsection B of Section 24-17-5 NMSA 1978 of the Continuing Care Act.

Subsection C of 9.2.24.8

The Department received one comment asking if a reasonable rate of return is appropriate for a non-profit organization. The Department believes it is. A non-profit entity is a business, just as a for-profit entity is a business. Each type of entity needs money to keep the business going. The same ratio can be applied to either.

Reasonable Return on Investment as it Pertains to Rates and Fees

Subsection B of 9.2.24.12

The Department received one comment stating that the 90-day U.S. Treasury bill rate is a low, but positive measurement, but that the six-percentage point return on investment would be excessive for a non-profit organization. The commenter suggests having a separate reasonable return standard for non-profits. The Department's position is that this is not excessive. To ensure an entity survives and to secure the residents' investments, the entity must invest. No separate standard is needed for non-profits.

Actuarial Studies

9.2.24.17

The Department received two comments suggesting that actuaries who perform a community's comprehensive actuarial analysis provide their best judgment of the community's chances of remaining viable for the next five to ten years and rate the probability of five to ten years of viability on a scale of poor, average, or good. The commenters suggest that, for comparison, residents and prospective residents be provided the ratings that have been assigned to every Type-A community in the state. The commenters expressed concern about residents in Type-A communities investing their life savings to pay the buy-in fees to such communities and those communities going bankrupt, rendering residents destitute. While the Department understands those concerns, the Department does not have the statutory authority to require this in the rule. Additionally, it would be difficult to secure an actuary who would make this type of viability judgment. The Department does believe, however, that the requirements of the new rule align nicely with the changes to the Continuing Care Act and go a long way in providing necessary protection and transparency to residents.

Katrina Hotrum-Lopez
Katrina Hotrum-Lopez, ALTSD Secretary

July 12, 2022
Date

TITLE 9 HUMAN RIGHTS
CHAPTER 2 AGE
PART 24 THE ADMINISTRATION OF THE CONTINUING CARE ACT

9.2.24.1 ISSUING AGENCY: Aging and Long-Term Services Department.
[9.2.24.1 NMAC - Rp, 9.2.24.1 NMAC, 07/26/2022]

9.2.24.2 SCOPE: This rule applies to for-profit and nonprofit continuing care communities, and the general public.
[9.2.24.2 NMAC - Rp, 9.2.24.2 NMAC, 07/26/2022]

9.2.24.3 STATUTORY AUTHORITY: This rule is adopted by authority of the secretary pursuant to Subsection E of Section 9-23-6 NMSA 1978, by authority of the Continuing Care Act, Sections 24-17-1 through 24-17-18 NMSA 1978, and by authority of the department pursuant to Subsection B of Section 28-4-6 NMSA 1978.
[9.2.24.3 NMAC - Rp, 9.2.24.3 NMAC, 07/26/2022]

9.2.24.4 DURATION: Permanent.
[9.2.24.4 NMAC - Rp, 9.2.24.4 NMAC, 07/26/2022]

9.2.24.5 EFFECTIVE DATE: July 26, 2022, unless a later date is cited in the history note at the end of a section.
[9.2.24.5 NMAC - Rp, 9.2.24.5 NMAC, 07/26/2022]

9.2.24.6 OBJECTIVE: This rule is promulgated for the purpose of administering certain provisions of the Continuing Care Act, Sections 24-17-1 through 24-17-18 NMSA 1978, and for establishing the terms and conditions under which continuing care communities may increase the rates and fees they charge residents pursuant to Paragraph (11) of Subsection B of Section 24-17-5 NMSA 1978.
[9.2.24.6 NMAC - Rp, 9.2.24.6 NMAC, 07/26/2022]

9.2.24.7 DEFINITIONS: The following terms are used in this rule:

A. **"affiliate"** means a person (which is defined by the Continuing Care Act as an individual, corporation, partnership, trust, association or other legal entity) having a five percent or greater interest in a provider;

B. **"ALTSD"** means the aging and long-term services department;

C. **"community"** means a retirement home, retirement community, home for the aged or other place that undertakes to provide continuing care, such as a life plan community;

D. **"continuing care"** means furnishing, pursuant to a contract that requires entrance or advance fees and service or periodic fees, independent-living and health or health-related services. Entrance or advanced fees do not include security or damage deposit fees that amount to less than three months' service or periodic fees. These services may be provided in the community, in the resident's independent living unit or in another setting, designated by the continuing care contract, to an individual not related by consanguinity or affinity to the provider furnishing the care. The services include, at a minimum, priority access to a nursing facility or hospital either on site or at a site designated by the continuing care contract;

E. **"cost of care"** means the direct cost of providing medical care or health-related supportive services to residents;

F. **"cost of operating the continuing care community"** means the indirect cost of providing care to residents; it includes administrative costs, depreciation expenses, recurring and nonrecurring costs, ordinary and extraordinary costs, capital improvement and replacement costs, and all other costs associated with running a continuing care community, other than cost of care;

G. **"economic necessity"** means insolvency or circumstances where funds are lacking to maintain a reasonable level of service and care for residents, including the inability to meet loan or bond requirements, or having insufficient funds to comply with master trust indenture or a future service obligation, where, under GAAP accounting, the expenses are greater than future revenue;

H. **"expenses"** mean cost of care plus cost of operating the continuing care community;

I. **"fees" or "assessments"** mean entrance fees, deposits, monthly service fees and any other sum of money which a resident must pay to a provider;

J. **"GAAP"** means generally accepted accounting principles; it refers to a set of widely accepted accounting standards, set by the financial accounting standards board, and used to standardize financial accounting of public companies;

K. **"gift income"** means income from any gift or grant, or portion thereof, that is used to pay for or offset an expense;

L. **"income"** means all income received by a continuing care community during a reporting period; income includes operating income, investment income, gift income, and all other forms of income;

M. **"investment income"** means income received by a continuing care community on investments. Investment income does not include income on resident trust accounts;

N. **"liquid reserves"** means cash or other assets that are available within 60 days to satisfy a community's expenses and that do not include real property or interests in real property;

O. **"net income"** means income minus expenses;

P. **"net operating expenses**" means the total costs of operating a community, including taxes and insurance but not including amortization, depreciation or long-term debt service;

Q. **"person"** means an individual, corporation, partnership, trust, association or other legal entity;

R. **"policy"** is a deliberate system of guidelines to guide decisions and achieve rational outcomes. It is a statement of intent and is implemented as a procedure or protocol;

S. **"provider"** means the owner or manager of a community that provides, or offers to provide, continuing care;

T. **"reserves"** means capital set aside for future expenses and includes liquid reserves and other reserves;

U. **"resident"** means an actual or prospective purchaser of, nominee of or subscriber to a continuing care contract;

V. **"return on investment"** for a for-profit corporation means net income divided by the sum of common stock equity, preferred stock equity and long-term debt; for any other form of business enterprise, it means a ratio that is statistically equivalent to the return on investment for a for-profit corporation;

W. **"type A agreement"** means, as defined in Subsection K of Section 24-17-3 NMSA 1978, an extensive entrance-fee contract that includes housing, residential services, amenities and unlimited specific health-related services with little or no substantial increase in monthly payments, except to cover normal operating costs and inflation adjustments; and

X. **"type B agreement"** means, as defined in Subsection L of Section 24-17-3 NMSA 1978, a modified entrance-fee contract that includes housing, residential services, amenities and a specific amount of health care with no substantial increase in monthly payments, except to cover normal operating costs and inflation adjustments. After the specified amount of health care is used, persons served pay either a discounted rate or the full per diem rates for required health care services.

[9.2.24.7 NMAC - Rp, 9.2.24.7 NMAC, 07/26/2022]

9.2.24.8 RATE AND FEE INCREASES:

A. A continuing care contract shall state, in clear and understandable language, when rates and fees will be subject to periodic increases and what the policy for increases will be. The contract shall include the policy for increases and shall clearly indicate which of the four factors referenced in Subsection C of 9.2.24.8 NMAC it will utilize for rate and fee increases.

B. A continuing care community shall give residents at least 30 days advance written notice of any rate or fee increase.

C. A continuing care community shall base rate and fee increases on one or more of the following four factors referenced in its contract and policy, and no others:

(1) economic necessity as defined in Subsection G of 9.2.24.7 NMAC;

(2) the reasonable cost of operating the continuing care community as referenced in 9.2.24.9 NMAC;

(3) the cost of care as referenced in 9.2.24.10 NMAC; and

(4) a reasonable return on investment as referenced in 9.2.24.12 NMAC.

D. Any publicly available documentation used by a continuing care community to support a rate or fee increase shall conform to applicable GAAP standards and shall be included in the notice provided to residents referenced in Subsection B of 9.2.24.8 NMAC. Additionally, the community shall supply the mathematical calculations used to support a rate or fee increase to at least two decimal places. Any non-public documentation shall be aggregated into summarized budgets or pro forma financials.

E. A continuing care community may contractually base rate and fee increases on published federal economic data used for the purpose of cost of living and inflation adjustments provided that such increases do not exceed what would otherwise be allowable under this rule.
[9.2.24.8 NMAC - Rp, 9.2.24.8 NMAC, 07/26/2022]

9.2.24.9 COST OF OPERATING THE CONTINUING CARE COMMUNITY:

A. A continuing care community shall identify with reasonable specificity all costs of operating the continuing care community, including any fees paid to affiliated persons or entities.

B. Any unreasonable cost of operating the continuing care community shall be charged against the common stock equity of a for-profit corporation, or against a comparable measure of the assets less liabilities for any other type of business enterprise.
[9.2.24.9 NMAC - Rp, 9.2.24.9 NMAC, 07/26/2022]

9.2.24.10 COST OF CARE INCREASES:

A. Rate and fee increases based on cost of care increases for providing medical care or health-related supportive services to an individual resident shall be governed by any applicable terms of the continuing care contract. If there are no applicable terms, such rate and fee increases shall be considered general cost of care increases.

B. General cost of care increases shall be treated as an expense item by a continuing care community.
[9.2.24.10 NMAC - Rp, 9.2.24.10 NMAC, 07/26/2022]

9.2.24.11 HISTORICAL AND CURRENT DATA:

A. A continuing care community shall base rate or fee increases on four years of historical data plus current fiscal year projections. However, the community may consider a deviation from historical data when exigent circumstances exist making the historical data inapplicable to the circumstances surrounding the need for the present increase.

B. A continuing care community that has been in operation for less than four years shall base rate or fee increases on historical data for the entire period it has been in operation plus current fiscal year projections.

C. A continuing care community shall make available to residents copies of any publicly available data used to support a rate or fee increase. Non-public data will be aggregated when permissible. The data shall be made available at the time the continuing care community gives notice of a rate or fee increase, and it shall be made available at no cost to the residents.
[9.2.24.11 NMAC - Rp, 9.2.24.12 NMAC, 07/26/2022]

9.2.24.12 REASONABLE RETURN ON INVESTMENT AS IT PERTAINS TO RATE AND FEE INCREASES:

A. A reasonable return on investment shall be determined by comparing the continuing care community's historical and current return on investment data to secondary market interest rate data published by the federal reserve board for 90-day United States treasury bills.

B. A return on investment consistently greater than six percentage points higher than the annual average secondary market interest rate on 90-day United States treasury bills shall be presumed to be unreasonable. The presumption is rebuttable.
[9.2.24.12 NMAC - Rp, 9.2.24.13 NMAC, 07/26/2022]

9.2.24.13 ACCOUNTING DATA FOR RATE AND FEE INCREASES SHALL BE SPECIFIC TO THE CONTINUING CARE COMMUNITY: A continuing care community shall base rate or fee increases on accounting data that is specific to the community. A continuing care community shall not base rate or fee increases on companywide data, statewide data, nationwide data, or any other accounting data that is not community specific.
[9.2.24.13 NMAC - Rp, 9.2.24.14 NMAC, 07/26/2022]

9.2.24.14 EXISTING CONTRACTUAL PROVISIONS NOT ABROGATED: This rule shall not abrogate any provision relating to rate and fee increases in a continuing care contract that is entered into prior to the effective date of this rule.
[9.2.24.14 NMAC - Rp, 9.2.24.15 NMAC, 07/26/2022]

9.2.24.15 FINANCIAL RESERVES:

A. Liquid Reserves:

(1) A community must maintain liquid reserves and the provider must disclose this information to ALTSD, and actual and prospective residents in its annual disclosure statement.

(2) The liquid reserves shall be sufficient to assure payment of debt obligations and an ongoing ability to provide services to residents.

(3) A community that provides a type A agreement shall, at all times, maintain liquid reserves equal to the principal and interest payments due for a 12-month period on all accounts of any mortgage loan and other long-term debt, as well as three months' worth of net operating expenses.

B. Other Reserves:

(1) Deposits or entrance fees paid by or for a resident constitute reserves which shall be held in trust for the benefit of the resident in a federally insured New Mexico bank, separate from the community's operating accounts, until:

(a) the resident has occupied the resident's unit; or

(b) the resident's contract cancellation period has ended, whichever occurs later.

(2) A community that provides type B agreements shall calculate required reserves on a prorated basis for residents who fall under type B agreements.

C. Certification of Compliance Regarding Financial Reserves:

(1) A provider shall make available to the certified public accountant who is responsible for the community's annual audited financial statement and audit report, a copy of this rule and a copy of the Continuing Care Act, specifically the requirements for financial reserves referenced in Section 24-17-6 NMSA 1978.

(2) The certified public accountant shall certify whether, based upon the audit, the community meets the financial reserve requirements delineated in this rule and in the Continuing Care Act. If the certified public accountant finds that the community does not meet the financial reserve requirements delineated in this rule and in the Continuing Care Act, then the certified public accountant shall state the reason(s) for the community's deficiencies.

D. Corrective Action Plan: If the certified public accountant is unable to attest that the community meets the financial reserve requirements delineated in this rule and in the Continuing Care Act, then the provider shall submit a proposed Corrective Action Plan to ALTSD.

[9.2.24.15 NMAC - N, 07/26/2022]

9.2.24.16 DISCLOSURE STATEMENT AND PROVIDER CERTIFICATION:

A. Annual Disclosure Statement to ALTSD:

(1) No later than July 1, 2022, and each year thereafter, within 180 days after the end of a community's fiscal year, a provider shall submit a disclosure statement, any amendments to that statement, and any proposed corrective action plan to ALTSD. The annual disclosure statement shall include, at a minimum, all information delineated in Subsection B of Section 24-17-4 NMSA 1978 and the information delineated in Paragraphs (2) and (3) of Subsection A of 9.2.24.16 NMAC. Submittal is completed electronically to ALTSD by emailing ALTSD.CCRC@state.nm.us. In the event a fillable template is created by ALTSD for submission of disclosure statements, providers shall use the ALTSD template. ALTSD shall notify providers when a template is available for use and provide instructions for accessing it.

(2) The disclosure statement shall include the extent of any guarantee or cross collateralization if a provider guarantees the debt of another legal entity or otherwise cross collateralizes its assets for the benefit of another legal entity.

(3) Pursuant to Paragraph (13) of Subsection B of Section 24-17-4 NMSA 1978, the disclosure statement shall include a sample copy of the contract used by the provider. The sample contract shall include all the minimum requirements of a continuing care contract as prescribed by Subsection B of Section 24-17-5 NMSA 1978.

B. Provider Certification of Compliance with the Continuing Care Act:

(1) Pursuant to Section 24-17-17 NMSA 1978, in conjunction with its submission of the annual disclosure statement, the provider shall certify to ALTSD:

(a) that the disclosure was provided to each actual resident or the residents' association within 180 days after the end of the community's fiscal year;

(b) that the disclosure statement was provided to each prospective resident at least seven days before the provider entered into a continuing care contract with the prospective resident, or prior to the prospective resident's first payment, whichever occurred first;

(c) that the disclosure includes all the information delineated in Subsection B of Section 24-17-4 NMSA 1978;

(d) whether it is a community that provides type A or type B agreements;

(e) that it adopted and follows a written policy establishing the procedure and criteria that are applicable when deciding to transfer residents from one level of care to another as required by Section 24-17-12 NMSA 1978; and

(f) that it has taken appropriate steps to encourage and facilitate the establishment of a resident association in each facility, and that the provider complies with all of the requirements of Section 24-17-13 NMSA 1978.

(2) The provider shall further certify whether in the past five years:

(a) it has been issued a notice of violation by ALTSD, pursuant to Section 24-17-16 NMSA 1978;

(b) the attorney general filed an action against the provider in a court of competent jurisdiction pursuant to Section 24-17-18 NMSA 1978;

(c) the attorney general has brought a legal action in district court against the provider in order to restrain or prevent violations of the Continuing Care Act or these regulations pursuant to Section 24-17-10 NMSA 1978; and

(d) if the attorney general has filed an action against the provider pursuant to Subparagraph (b) or (c) of Paragraph (2) of Subsection B of 9.2.24.16 NMAC. If a legal action was filed then the provider shall indicate the status of that matter, as well as whether any civil penalties or injunctive relief were imposed upon the provider. Specifically, if civil penalties or injunctive relief were imposed then the provider shall indicate the amount of the penalty, or the nature of the temporary or permanent injunctive relief. However, no confidential information that is subject to a settlement agreement with the attorney general shall be disclosed.

[9.2.24.16 NMAC - N, 07/26/2022]

9.2.24.17 ACTUARIAL STUDIES:

A. Continuing care communities that provide type A or type B agreements shall include in their annual disclosure to ALTSD, as well as to actual and prospective residents, a summary of a comprehensive actuarial analysis within the last five years and an annual future-service obligation calculation by an actuary who is a member of the American academy of actuaries and who is experienced in analyzing continuing care communities.

B. The provider shall include with the actuarial analysis and annual future-service obligation calculation, as required by Subsection A of 9.2.24.17 NMAC and the Continuing Care Act, a certification signed by the actuary that they are a member of the American academy of actuaries and that they are experienced in analyzing continuing care communities.

C. A provider shall make available to the actuary, who is responsible for the comprehensive actuarial analysis and future service obligation, a copy of this rule and a copy of the Continuing Care Act, specifically Paragraph (11) of Subsection B of Section 24-17-4 NMSA 1978.

[9.2.24.17 NMAC - N, 07/26/2022]

9.2.24.18 NOTICE OF VIOLATIONS:

A. ALTSD shall review disclosure statements and corrective action plans filed pursuant to the Continuing Care Act for compliance with the Act and with these rules. After its initial review, if ALTSD has any questions regarding the submissions, then it may contact the provider to gather clarification and informally discuss its questions.

B. If ALTSD determines that a person or an organization has engaged in, or is about to engage in, an act or practice constituting a violation of the Continuing Care Act or any rule adopted pursuant to the Act, then ALTSD shall issue a notice of violation in writing to that person or organization and send copies to the resident association of any facility affected by the notice.

C. The notice of violation shall state the following:

(1) a description of the violation at issue;

(2) the action that, in the judgment of ALTSD, the provider should take to conform to the law or the assurances that ALTSD requires to establish that no violation is about to occur;

(3) the compliance date by which the provider shall correct any violation or submit assurances;

(4) the requirements for filing a report of compliance; and

(5) the applicable sanctions for failure to correct the violation or failure to file the report of compliance according to the terms of the notice of violation.

D. At any time after receipt of a notice of violation, the person or organization to which the notice is addressed, or ALTSD, may request a conference. ALTSD shall schedule a conference within 30 days of ALTSD's receipt of a request for a conference. Requests for a conference may be submitted to ALTSD via email at ALTSD.CCRC@state.nm.us.

E. The purpose of the conference is to discuss the contents of the notice of violation and to assist the provider in complying with the requirements of the Continuing Care Act. In certain situations, if both the provider and ALTSD concur, then ALTSD may request that the provider undergo special audit procedures by a certified public accountant to help resolve the alleged violation. A representative of the resident association at any facility affected by the notice shall have a right to attend the conference.

F. A person receiving a notice of violation shall submit a signed report of compliance as provided by the notice. ALTSD shall send a copy to the resident association of any facility affected by the notice.

G. Upon receipt of the report of compliance, ALTSD may take steps to determine that compliance has been achieved.

H. Any time after ALTSD issues a notice of violation, it may send the attorney general a written report alleging a possible violation of the Continuing Care Act or any rule adopted pursuant to the Act.
[9.2.24.18 NMAC - N, 07/26/2022]

History of 9.2.24 NMAC: [RESERVED]

History of Repealed Material:
9.2.24 NMAC, Rate and Fee Increases by Continuing Care Communities (filed 01/09/2006) Repealed effective 07/26/2022.

Other: 9.2.24 NMAC, Rate and Fee Increases by Continuing Care Communities (filed 01/09/2006) Replaced by 9.2.24 NMAC, The Administration of the Continuing Care Act, effective 07/26/2022.