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**TRAGIC AND PREVENTABLE**  
**Investigation by Disability Rights New Mexico**  
**of the Deaths of**  
**Alex Montoya and Cochise Bayhan**

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November, 2014



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Cover photo from Department of Public Safety Report, Incident No. 2013-19153, ORI No. NMNSP0200

## I. Introduction

Disability Rights New Mexico (DRNM) conducted an investigation into the deaths of Mr. Alex Montoya and Mr. Cochise Bayhan on October 24, 2013. Both men had been inpatients at the New Mexico Behavioral Health Institute and were discharged to a boarding home in Las Vegas, New Mexico. The Office of the Medical Investigator concluded that each man died of carbon monoxide poisoning. The men lived in a shed without plumbing and without proper heating or ventilation. The shed was “not designed or suitable for human occupancy or habitation.” The boarding home was not licensed as there is no licensing for these kinds of residences in New Mexico.<sup>1</sup>

In this report DRNM examines the conditions in which the two men lived, the circumstances of their death, and the absence of oversight of boarding homes, where many people with serious mental illness in New Mexico reside, that may have prevented their deaths.

DRNM, an independent non-profit organization, has been the state’s designated protection and advocacy (P&A) agency since 1979. Congress found that people with mental illness are “vulnerable to abuse and serious injury” and created the P&A agencies to protect and promote the rights of people with disabilities, authorizing them to “investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.” 42 U.S.C. §10801 (b). DRNM can conduct investigations in any facility in New Mexico providing care or treatment, including places in the community where individuals with mental illness reside. 42 USC § 10802 (4)(B)(ii); 42 USC § 10805 (a)(1)(A).

DRNM received reports about the deaths of Alex Montoya and Cochise Bayhan at a Las Vegas, NM boarding home from Shela Silverman, an advocate from the Mental Health Association of New Mexico. DRNM also received an inquiry from Karen Armstrong, Protection and Advocacy for Individuals with Mental Illness Program Coordinator, of the Substance Abuse and Mental Health Services Administration (SAMHSA/CMHS). DRNM staff also read newspaper reports of the deaths in the Las Vegas Optic and the Albuquerque Journal.

## II. Description of Relevant Parties

**Alex Montoya:** age 61, was living at the Denise Encinias boarding home when he died of carbon monoxide poisoning on October 24, 2013. Mr. Montoya was a person with serious mental illness and had been receiving outpatient mental health services from NM Behavioral Health Institute Community-Based Services (NMBHI/CBS) since November 13, 2009. He had been

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<sup>1</sup> Unregulated boarding homes exist in many New Mexico communities, not just Las Vegas. In the last several months, the Bernalillo County Environmental Health Manager and the Director of the City of Albuquerque Family and Community Services Department Health and Human Services Division have called DRNM with reports of boarding homes that do not meet health and safety standards and for which there is no comprehensive oversight.

admitted to NMBHI in-patient services at least 19 times, and in 2009 was placed into board and care facilities and NMBHI. Mr. Montoya's mother was appointed his health care surrogate and Ms. Leora Gomez was his appointed mental health treatment guardian. Ayudando Guardians was Mr. Montoya's representative payee for his Social Security benefits.

**Cochise Bayhan:** age 56, was living at the Denise Encinias boarding home when he died of carbon monoxide poisoning on October 24, 2013. He had a history of serious mental illness and no known support system. Prior to admission to NMBHI on September 19, 2013, he received outpatient mental health services in Carlsbad, NM and in-patient services from another hospital. He was discharged from NMBHI to the Denise Encinias boarding home on October 9, 2013. Mr. Bayhan had a high school education and some experience in the Air Force. Mr. Bayhan was admitted to the NMBHI/CBS outpatient services for the first and only time on October 15, 2013. Mr. Bayhan did not have a court appointed treatment guardian, probate guardian or a person designated to manage his Social Security check.

**New Mexico Behavioral Health Institute:** The New Mexico Behavioral Health Institute (NMBHI) is the only state owned and operated psychiatric hospital in New Mexico. NMBHI is located at 3695 Hot Springs Boulevard in Las Vegas, New Mexico. It has five clinical divisions serving a wide range of public needs. Each division is separately licensed and has its own admission criteria. The Adult Psychiatric Division at NMBHI provides court-ordered and voluntary treatment to individuals living with mental illnesses that have severely impaired their functioning and their ability to be maintained in the community. It is the most restrictive psychiatric setting in New Mexico.

**New Mexico Behavioral Health Institute/Community Based Services:** NMBHI/CBS is an outpatient program of NMBHI that offers Outpatient Restorative Services, Mental Health/Substance abuse Services, Case Management for some Medicaid Waiver Programs and Foster Grandparent and Senior Companion Programs. The Mental Health component provides individualized assertive and comprehensive community-based treatment. Both Mr. Montoya and Mr. Bayhan were receiving mental health services from NMBHI/CBS at the time of their deaths. NMBHI/CBS outpatient services are located on 700 Friedman Avenue in Las Vegas, New Mexico.

**Denise Encinias Boarding Home:** The Denise Encinias boarding home is located at 3511 Ning Street in Las Vegas, New Mexico, and it was the place where both Mr. Montoya and Mr. Bayhan were residing at the time of their deaths. Both men were discharged from the NMBHI inpatient facility to this boarding home. According to Mrs. Encinias, owner/operator of the boarding home, she contacted NMBHI about having clients discharged to her facility and was told that she would be placed on a list and contacted when any individuals were discharged. Mrs. Encinias was contacted by NMBHI for placement of both of Mr. Montoya and Mr. Bayhan. Mrs. Encinias and her husband reside in a mobile home adjacent to the structure that served as the boarding home.

**New Mexico Department of Health (DOH).** This is the state agency responsible for the licensure or certification of health care facilities in New Mexico. It is also the agency that operates NMBHI.

### III. Summary of the Incident

Mr. Alex Montoya and Mr. Cochise Bayhan had been inpatients at NMBHI. Each was discharged from the hospital to the Encinias boarding home. Their living quarters was not a home, an apartment or even a dormitory; it was a slightly modified storage shed. Electricity was provided by running an extension cord from the Encinias' single wide mobile home. There was no

*Paramedics... noticed a strong odor of gas. After the paramedics examined both men, the supervisor on scene told everyone to leave the shed for their safety as there was nothing to be done for either man.*

plumbing of any kind. Days before their deaths, Mr. Encinias installed a used propane heater, apparently without adequate provision for ventilation. At around 10 p.m. on October 23, 2013, Mrs. Encinias made their beds, had them put on their pajamas, and told them to go to bed. At approximately 2:00 a.m. on October 24<sup>th</sup>, Mr. Encinias noticed that the light was still on in the shed so he went out to check on the men. He found them still sitting on the couch and they were unresponsive. He told Mrs. Encinias to call 911.

Paramedics were dispatched to 3511 Ning Road at 2:33 a.m. They noticed a strong odor of gas. After the paramedics examined both men, the supervisor on scene told everyone to leave the shed for their safety as there was nothing to be done for either man. The Gallinas Volunteer Fire Department arrived on the scene at approximately 3:10 a.m. They measured the carbon monoxide level which was at 185 parts per million, a level high enough to cause disorientation, unconsciousness, and death. The Office of the Medical Investigator field officer pronounced the men dead at 3:38 a.m.

### IV. Findings of the DRNM Investigation

Records reviewed by DRNM confirm that Mr. Montoya and Mr. Bayhan had each been admitted to NMBHI on multiple occasions for the treatment of schizophrenia.

According to the Office of the Medical Investigator report, Mr. Montoya and Mr. Bayhan died from the toxic effects of carbon monoxide and the manner of death was an "accident." The toxicology evaluation revealed a "fatal level of carboxyhemoglobin". Carbon monoxide in the shed where they died was measured at 183 parts per million. 150 to 200 parts per million can cause disorientation, unconsciousness and death.

The DPS/State Police report states that a Weather King portable storage building was purchased by the operator of the Encinias Boarding Home on September 20, 2013 for the "purpose of housing former NMBHI patients". The storage building rent-to-own agreement the

Encinias's signed had bold upper-case lettering "NOT DESIGNED OR SUITABLE FOR HUMAN OCCUPANCY OR HABITATION".

The boarding home was not licensed and had never been inspected by any state agency, NMBHI or a fire department. Mrs. Encinias believed that "Boarding Homes with less than five clients did not require licensing".

*The DPS/State Police report states that ... the storage building rent-to-own agreement the Encinias' signed had bold upper-case lettering "NOT DESIGNED OR SUITABLE FOR HUMAN OCCUPANCY OR HABITATION".*

To get clients referred to her boarding home from NMBHI, Mrs. Encinias spoke to social workers there and asked to be "put on a list to receive future clients". There were no other requirements for receiving such referrals.

Mrs. Encinias stated that as boarding home operator, she had to do "everything" for the people who lived there. "It's not landlord tenant." She stated that she fed them, gave them their medications per instructions from the outpatient provider NMBHI/CBS and made sure they showered. She also took them for appointments and helped them with their SSI. Her boarding home did not have a grievance policy, and if her clients had any complaints they could complain to her or to the outpatient provider.

There was no written rental agreement between either Mr. Montoya or Mr. Bayhan and the boarding home operator.

The Construction Industries Division (CID) report dated October 31, 2013, reflected many issues with the shed and multiple violations. The CID reports state that the shed had no natural ventilation; emergency escape and rescue openings did not meet requirements; carbon monoxide alarms installation in the vicinity of bedrooms with fuel-fired appliances was not provided; the Encinias' did not have a permit for altering the structure, which would include repairs, improvements, electrical wiring, plumbing, or mechanical work. Plumbing code violations included a lack of toilet facilities, no kitchen with sink, no sewage disposal and no water supply.

The CID report identified multiple LP Gas code violations: the propane cylinder was not secured to prevent tipping; a single stage regulator was used to operate the propane heater when a two-stage regulator system should have been used; the space heater vent was not extended above the eave; the vent pipe termination did not have a vent cap installed and the vent pipe was not secured; there was no manual shut off valve for space heater; the space heater should have been converted for use with LP gas; and the vent rollout switch had been removed from its bracket. The investigator asked that a criminal charge be brought for "failure to have propane-fed heater installation certified by a qualified installer or inspector of the bureau, should it be determined Mr. or Mrs. Encinias installed the propane heater".

The mental health treatment guardian for Mr. Montoya was only contacted by NMBHI twice, regarding medication approvals, and was never invited to any treatment team meetings. She was not contacted by NMBHI prior to their discharging Mr. Montoya to the Denise Encinias boarding home. Mrs. Encinias did not know that Mr. Montoya had a mental health treatment guardian.

The family of Mr. Montoya “didn’t think he had a choice” regarding whether he was discharged to the Denise Encinias boarding home

In 2010, the Department of Health repealed regulations entitled “Requirements for Adult Residential Care Facilities”, the former 7.8.2 NMAC (effective 8.31.2000) and replaced them with regulations called “Assisted Living Facilities for Adults”, 7.8.2 NMAC (effective 1.15.2010). Boarding homes were specifically covered under the prior regulations so they were subject to those licensing requirements.

## **V. Process and Sources for the DRNM Investigation**

The investigation relied on information gathered from reports available through the NM Office of Medical Investigator, the NM Behavioral Health Institute, the NM Behavioral Health Institute/Community Based Services, the NM State Police, the Construction Industries Division of the NM Regulation and Licensing Department and newspaper articles. In addition, DRNM conducted interviews with Boarding Home Operator/Owner Denise Encinias, the treatment guardian appointed for Mr. Montoya, and a family member of Mr. Montoya.

### **A. Interviews Conducted by DRNM**

#### **Denise Encinias Interview December 11, 2013**

A DRNM senior advocate met with Mrs. Encinias. He presented his card, described DRNM and told her that DRNM was conducting an investigation into the deaths of Mr. Montoya and Mr. Bayhan. He let her know her participation in the interview was completely voluntary. She consented saying she had nothing to hide.

Mrs. Encinias was asked how she established the boarding home. She said that that she called social workers at NMBHI and had been put on list for client placement. During the interview, Mrs. Encinias's daughter commented that “...if you want to have a client from the State Hospital you just call them; they put you on a list”, and “If you want a client you can meet the client and if the client wants to go with you, then you can take them home”. Mrs. Encinias stated that she did not have a business license for the home, and she was never contacted by State Licensing and

*Mrs. Encinias's daughter commented that “...if you want to have a client from the State Hospital you just call them; they put you on a list”, and “If you want a client you can meet the client and if the client wants to go with you, then you can take them home”.*

Certification, or any other state agency upon establishment of the home. She stated that the boarding home was never inspected by anyone, including the fire department. Mrs. Encinias said she was installing smoke detectors in the shed, but that she was never told by anyone what was needed.

Mrs. Encinias charged \$600.00 per month each for Mr. Montoya and Mr. Bayhan to stay in the home, which came from their Social Security checks.<sup>2</sup> She did not have a rental agreement with either client. Mr. Bayhan managed his own Social Security check and cashed his check and paid Mrs. Encinias each month. Ayudando Guardians was the payee for Mr. Montoya, and Mrs. Encinias had to send Ayudando Guardians all of Mr. Montoya's receipts. Ayudando Guardians had no contact with her otherwise.

Both clients lived next to the Encinias' residence in a shed that had no running water, and electricity was provided only through an extension cord from the Encinias residence. The propane heater had been installed by Mr. Encinias on October 20, 2013, three days before the deaths of Mr. Montoya and Mr. Bayhan. The propane heater was not inspected after installation. She said Mr. Encinias was working on plumbing for the shed, but since it had no bathroom the clients showered at the Encinias residence. Mrs. Encinias stated that both clients had access to the living area in her residence – a single wide mobile home which was always unlocked - and that someone was always at the residence.

Mrs. Encinias stated that she prepared meals and snacks at 8:30, 12:00 and 5:00 daily. She did not have a meal plan, and cooked something different every day. She fed the clients the same food she fed her family. Mr. Montoya and Mr. Bayhan were picked up by the NMBHI/CBS bus during the week and generally attended NMBHI/CBS activities from 8:00-1:30. Mrs. Encinias gave each man his medications per instructions from NMBHI/CBS; she took the prescriptions from NMBHI/CBS, called the pharmacy, and stored the medications at her residence. Mrs. Encinias was unaware that Mr. Montoya had a mental health treatment guardian until after his death. Both clients had access to the phone, and mail, and Mrs. Encinias allowed visitors.

There was no grievance policy for the boarding home. Mrs. Encinias said that any complaints would go through her, or the clients could contact NMBHI/CBS staff when they went for medications or attended Psychosocial Rehabilitation. The only contact made after admission was by a NMBHI social worker who called to see how Mr. Montoya was doing after he moved into the boarding home.

During the interview, Mrs. Encinias gave her account of the deaths of Mr. Montoya and Mr. Bayhan. She said that on October 21, 2013, she took Mr. Montoya for a flu and pneumonia shot. On October 24, 2013 Mrs. Encinias took Mr. Bayhan for physical at El Centro, a local health clinic, and both clients were doing well. On October 23, 2013 at 10:00 a.m. both clients were back for lunch, and both were watching TV. At 5:00 p.m., supper was served in the dining room of Mrs. Encinias' trailer, and the clients returned to their shed after supper. At 8:00 p.m.

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<sup>2</sup> In DRNM's interview with Ayudando Guardians, we were told that Mr. Montoya was charged \$500 per month.



meds were given out, and all was still okay. Mr. Montoya was snacking at 10:00 p.m. when she checked on both men and told them to go to bed. At 2:00 a.m., Mr. Encinias checked on them because the lights were still on in the shed. Mr. Encinias awoke Mrs. Encinias and told her that the clients were “not breathing”, not moving, and that they were “cold” to the touch. Mrs. Encinias called 911 and the ambulance and fire department arrived and told Mr. and Mrs. Encinias that the clients were “gone”. The Fire Department used a machine to check on the carbon monoxide.

### **Phone Interview with a family member of Mr. Montoya, December 13, 2013**

The family member said they were going to consult with an attorney to prepare a lawsuit. It wasn't about the money, the individual stated, it was about opening the doors for other people.

The family had several concerns about Mr. Montoya. They tried to complain to DOH about Alex's placement before. They didn't understand why he was just passed along and placed wherever. They were told that Mr. Montoya consented to the placement but they didn't think he actually had a choice.

The family member was asked about Mr. Montoya's discharge plan. The family was never called about his discharge. According to the family member, Mr. Montoya had said that he would let his mother know when he was getting out. The mother called the hospital for more information about how Mr. Montoya was doing but they wouldn't tell her. DRNM asked if they knew how Mr. Montoya ended up in this boarding home; the family member said the hospital will send them out to anyone who will take them.

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According to the family member, two family members had previously visited Mr. Montoya when he lived in boarding homes in Las Vegas. They had found Mr. Montoya wandering around town and in dumpsters. The place he was living in during their last visit [the Encinias boarding home] was a storage shed that the boarding home owners were trying to convert into a room. There was no running water and no bathroom. The owners were putting in a propane heater which looked rusty and old. The family was very worried because there was a very strong gas smell. The family confronted the owner and he said it was because they had just installed a new heater. The shed was small with a couch and two twin beds. Mr. Montoya was a smoker. The family told Mr. Montoya that he shouldn't be in there because there was no ventilation, but he (Mr. Montoya) told his family he was fine and they had the door open. Three or four days later, they got the call that Mr. Montoya had died.

The family was glad Mr. Montoya's death is being looked into. They are very concerned about the conditions of these homes. The family member knows of one that houses 20 people. The

neglect has to stop, the individual stated; the people who live in these homes are not treated like human beings.

## **B. DRNM\_Review of Documentary Evidence**

### **Newspaper reports**

Newspaper articles published shortly after the deaths of Mr. Montoya and Mr. Bayhan provided probable cause for DRNM to believe that they had been subject to neglect. On October 29, 2013, The Las Vegas Daily Optic published an article stating that "...two Behavioral Health Institute patients who were released into the care of a local boarding home were found dead last week, and state police are investigating. Carbon monoxide poisoning is suspected. Officers were dispatched to Ning Road at 2:33 a.m. off of 7th Street heading north and identified clients, Alex Montoya, age 61 and Cochise Bayhan, age 56. The local fire department measured carbon monoxide levels in the residence at 183 parts per million (above 150 to 200 parts per million), which can cause disorientation, unconsciousness and death. [1]

A follow-up article in the Las Vegas Daily Optic, dated November 6-7, 2013 said that "...the boarding home operators gave both clients, who lived in an outbuilding behind the Encinias residence, their medications at 8:30 pm. Both clients were checked on by Denise Encinias at 10:00 pm and told to go to bed. At 2:00 a.m., Joe Encinias noticed that the lights were still on and checked on them. Joe Encinias rushed back to the residence when he discovered both clients were not breathing and 911 was called. Emergency responders arrived and suspected carbon monoxide was involved in the deaths. Mrs. Encinias stated that both clients had moved into the outbuilding three weeks before their deaths and that an electric heater wasn't 'getting the building warm enough'. The Encinias' then installed a faulty propane heater that was given to them by a friend, and the heater was not checked by the gas company." [2]



A later article in the Las Vegas Daily Optic, dated April 2-3, 2014 said "Police note that the rent-to-own agreement Denise Encinias signed for the Weather King shed on Sept. 20, 2013, contained a disclaimer in bold, upper-case letters that the shed was "not designed or suitable for human occupancy or habitation". [3]

According to the article, "Denise Encinias, 41, and Jose Encinias, 47, who reside on the 3500 block of Ning Road, north of Las Vegas, have each been charged with two counts of neglect of a resident resulting in death, second degree felonies. Jose Encinias is also facing a misdemeanor count of installing an LP gas heater

without a license and not having that installation inspected or certified.” “The police affidavits state that Denise and Jose Encinias failed to obtain a business license from San Miguel County for their boarding home. San Miguel County Planning and Zoning supervisor Alex Tafoya told state police that any business, including boarding homes, must be licensed. Under the county’s ordinance, businesses operating in San Miguel County are subject to inspection to ensure that all state and county laws are being adhered to.” [3]

The article indicated that the shed where the men had lived was powered by extension cords from the Encinias residence, and that sheets of plastic were hung inside the shed, covering the

*“Four inspectors from the NM Regulation and Licensing Department, construction Industries Department ...identified 27 different construction code violations including 11 general construction code violations and 11 LP gas code violations.”*

windows and ceiling. It reported that a police affidavit stated that Mr. Encinias had installed a propane heater three days before the deaths but he did not have a license to install LP gas appliances and did not have his work inspected. [3]

The article further provided: “Four inspectors from the NM Regulation and Licensing Department, construction Industries Department inspected the shed after the deaths’, the police affidavits state. They identified 27 different construction code violations including 11 general construction code violations and 11 LP gas code violations.” [3]

“Under current state law, residential care facilities provi[d]ing ‘health care services’ are licensed and regulated. But many boarding homes, like the one operated by the Encinias family, are not licensed or regulated by the state or federal government.” [3]

### **New Mexico Department of Public Safety (New Mexico State Police) Reports**

DRNM reviewed several reports filed in this case by the State Police. These reports provided the following information.

At 2:33 a.m. on October 24, 2013, Paramedics were called to 3511 Ning Road in response to the 911 call from Denise Encinias. They entered the shed and saw two individuals that they proceeded to work on. They were subsequently determined to be deceased as indicated by the presence of “livor mortis along with fixed, dilated pupils”. The paramedics observed that the “shed was really, really hot” and was warmed with an electric heater and a second heater that was fueled with a propane tanks that were outside the shed. They noticed that the shed’s windows were sealed with plastic; and it had no restrooms and no refrigerator. The EMTs developed headaches while inside the shed and decided to leave and close the door. [4].

New Mexico State Police (NMSP) Officers were dispatched to 3511 Ning Road at the same time to respond to a 911 call [5]. When the officers arrived, the paramedics were attending to Mr.

Montoya and Mr. Bayhan. They noticed a strong odor in the shed, and told the paramedics to leave the building, since nothing could be done for Mr. Montoya and Mr. Bayhan. [6]

Gallinas Volunteer Fire Department arrived on the scene at approximately 3:10 a.m. with a Firefighter, who was wearing a full body protective suit with air supply. He entered the portable building through the front door with a device used to detect gases, and within two feet detected carbon monoxide.

*Gallinas Volunteer Fire Department arrived on the scene .... He entered the portable building through the front door with a device used to detect gases, and within two feet detected carbon monoxide.*

They exited the building and re-entered to identify the location with the largest reading of carbon monoxide and the highest reading was 185 parts per million, despite Mr. Encinias having shut off the propane after the 911 call. Per the United States Product Safety Commission, "At sustained CO concentrations above 150 to 200 ppm, disorientation, unconsciousness, and death are possible." ("Carbon Monoxide Question and Answers", United States Product Safety Commission website). [7]

At 3:38 a.m. on October 24, 2013, an Office of the Medical Investigator field investigator pronounced Mr. Montoya and Mr. Bayhan dead. [5]

At 11:26 a.m. on October 24, 2013, the NMSP obtained a search warrant, and at 11:34 a.m., NMSP did a walkthrough of the scene. Per the Supplement Report [8], the scene was a "Weather King" portable storage building, with wooden siding and a green metal roof, located west of the Encinias' mobile home on Ning Drive. Two propane bottles were located on the ground on the north side of the building. The building had windows on the south side, one on the east side, and two to the north, which were covered with plastic, which was later removed by the fire department. The front doorway led to a living room with a small table in the southeast corner, a large television on the north wall, an electric heater in the southwest corner, and in the northwest corner of the room, a brown "Perfection" brand propane heater. The west half of the living room ceiling was open to the attic space of the building, which was not insulated, and had been covered with clear plastic. In addition, there was an unfinished partition separating the west end of the building from the living room area that appeared to be a bedroom, which had beds in the southwest and northwest corners.

The bodies of Mr. Montoya and Mr. Bayhan were on a couch along the south wall. Mr.



Montoya was sitting on the east end of the couch. He appeared to have vomited on his chest, and was in stages of livor mortis, or a settling of the blood in the body, leading to a purple/red discoloration of the skin. Mr. Bayhan's body was on the west end of the couch, and he was also in the stages of livor mortis. Both men had medical debris on their bodies. [8]

At 6:27 a.m. on October 24, 2013, Jose Encinias voluntarily agreed to be interviewed by the NMSP. Mr. Encinias said that he and his wife began boarding patients in the Spring of 2013. They contacted NMBHI and arranged for Mr. Montoya to live with them. He was their first patient. Mrs. Encinias was the main contact for NMBHI, and she took patients to therapy sessions, while Mr. Encinias did maintenance work. Mr. Encinias stated that boarding homes with less than five patients did not require licensing, and that their boarding home was not licensed. Mr. Encinias discussed Mr. Montoya's return to NMBHI for erratic behavior and how he had another patient living in their mobile home residence while Mr. Montoya was back at NMBHI. [5]

Mr. Encinias said that he and his wife purchased the Weather King shed for \$6,000 before Mr. Montoya's and Mr. Bayhan's discharge, for the purpose of housing former NMBHI patients, and he referred to the shed as an "apartment", but he stated that "it's supposed to be used like a shed" but he said he would live in it. Mr. Encinias said that the shed had had no plumbing or heat source, and that Mr. Montoya and Mr. Bayhan used the bathroom in the mobile home that was the Encinias' residence. Mr. Encinias stated he ran an electric cord to an electric heater, but it was insufficient to heat the shed, so he installed a propane heater inside the shed with tanks on the outside of the building. He noted that he was aware the shed was not ventilated, but he said the door allowed air to enter the building. He noted that, Mr. Montoya's mother had visited several days prior to his death, and stated she was not happy with the living conditions in the shed. [5]



The last time Mr. Encinias saw Mr. Montoya and Mr. Bayhan alive was at 10:00 p.m. on October 23, 2013, and they were watching television. At approximated 2:00 a.m. on October 23, Mr. Encinias noticed that the light was still on in the shed, and when he checked on Mr. Montoya and Mr. Bayhan, he found them in the same positions in which he left them, and that they were both unresponsive. According to Mr. Encinias, the propane heater was still on. He asked Mrs. Encinias to call 911. [5]

At 7:30 a.m. on October 24, 2013, Mrs. Encinias voluntarily agreed to be interviewed by NMSP, stating she had nothing to hide. She said she had started the boarding home seven months ago, and got put on a list to receive future clients. Mrs. Encinias said she was called by a social worker about placing Mr. Montoya in her boarding home; Mrs. Encinias agreed, and Mr. Montoya became her first patient. A contract was signed by Mrs. Encinias, and among her obligations was what she would charge Mr. Montoya, and that she was to provide food and

housing to him.<sup>3</sup> She identified her operation as the “Encinias Boarding Home.” Mrs. Encinias described what she did at the home: “You have to do everything for them. It’s not landlord tenant. You have to feed them, give them their meds, make sure they shower, clean their house. I do everything. I take them for appointments. Help them with SSI.” Mr. Montoya was discharged to Mrs. Encinias, and she noted that “NMBHI staff did not visit” her house prior to Mr. Montoya’s release. Mr. Montoya lasted a month before being returned to NMBHI on July 15, 2013. Another patient was sent to the boarding home at this time, and he remained at the home until Mr. Montoya returned and Mr. Bayhan arrived on October 9, 2013. Mr. Montoya and Mr. Bayhan were put in a shed that Mrs. Encinias described as the “beginning of a house”, and she said that the shed was initially heated with an electric heater, but it didn’t properly heat the shed, so Mr. Encinias installed a propane heater given to them by a friend three days prior to the deaths of Mr. Montoya and Mr. Bayhan. Mrs. Encinias said that on October 20, 2013, Mr. Montoya’s family visited him. [5]

*She was woken up by Mr. Encinias, who “came in screaming” and told her to call 911, as “you could just look and tell” that both Mr. Montoya and Mr. Bayhan were deceased.*

The last time Mrs. Encinias saw Mr. Montoya and Mr. Bayhan alive was at approximately 10:00 p.m. on October 23, when she gave both men their medications, made their beds, and told them to put on their pajamas. She was awakened by Mr. Encinias, who “came in screaming” and told her to call 911, as “you could just look and tell” that both Mr. Montoya and Mr. Bayhan were deceased. [5]

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On October 28, 2013, at 1:10 p.m., NMSP met with the owner of Floyd’s Rental in Las Vegas, NM and Chief Martinez, who provided a copy of the rent-to-own agreement. The price was \$8,120 with a monthly payment of \$403.98 and a final price of \$14,543.28. The Terms and Conditions of Sale were signed by Denise Encinias and dated September 20, 2013 with bold upper-case lettering, “**NOT DESIGNED OR SUITABLE FOR HUMAN OCCUPANCY OR HABITATION.**” [5]

### **Construction Industries Division Reports, October 31, 2013**

A Construction Violation Determination report found that there were multiple code violations, as follows:

1. The structure shall have natural ventilation through windows, doors, louvers or other openings to the outdoor air. This was not complied with as the windows and ceilings were covered with plastic.

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<sup>3</sup> DRNM was informed by Ayudando Guardians, the representative payee, that there was only a verbal agreement and no written contract.

2. All emergency escape and rescue openings shall have a minimum net clear opening of 5.7 square feet. The windows, which were 2 x 3, did not meet this egress requirement.
3. For new construction, an approved carbon monoxide alarm shall be installed outside of each separate sleeping area in the immediate vicinity of the bedrooms in dwelling units within which fuel-fired appliances are installed and in dwelling. This was not provided.
4. No building or structure shall be altered, repaired, moved, improved, and no electrical wiring plumbing or mechanical work may be installed or repaired unless the applicable permit has first been obtained. No permits were obtained for this structure. [\[9\]](#)

The report further identified LP Gas code violations:

1. Propane cylinder was installed directly on the ground and was not secured to prevent tipping over. Propane cylinder was being used to operate the space heater inside the building.
2. A single stage regulator was being used to operate the space heater inside the building. Code requires either a two-stage regulator system or an integral two-stage regulator.
3. Space heater vent terminated through the north exterior wall and was not extended above the eave.
4. Vent pipe termination must have a listed vent cap installed. Vent cap installed was for a fan assisted appliance.
5. Vent pipe connection to the back of the space heater was not secured.
6. An accessible and approved manual shut off valve must be installed for space heater.
7. The space heater is to be converted for use with LP gas. Burner orifice installed in burner was stamped #48 indicating if the heater was used to LP gas it would have an input rating of 46,983 btu at sea level. The space heater data tag rating was 19,000 btu.
8. Vent roll out switch had been removed from its bracket near the space heater draft diverter and left lying on or near the floor.



A plumbing code violation report identified five violations but they did not appear to have contributed to the carbon monoxide levels in the shed. The violations were a lack of toilet facilities, lack of kitchen area with sink, lack of sewage disposal and lack of water supply.

Mr. Bailey asked that a criminal charge for failure to have the propane-fed heater installation certified by qualified installer or inspector of the bureau, should it be determined Mr. or Mrs. Encinias installed the propane heater. [\[9\]](#)

### **Office of the Medical Investigator’s Death Investigation Summaries for Mr. Montoya and Mr. Bayhan, dated November 26, 2013**

The reports included a report of drug analysis and photographs of the scene and photographs taken during autopsy. The Death Investigation Summary for Mr. Montoya, a 61-year-old male, states the cause of death was the toxic effects of carbon monoxide and manner of death was accident. The Summary and Opinion stated that “Mr. Montoya had a bright red cherry discoloration of his blood, skeletal muscle and organs and a black chess piece in his stomach. Toxicology evaluation revealed a fatal level of carboxyhemoglobin that is a chemical formed

“Mr. Montoya had a bright red cherry discoloration of his blood, skeletal muscle and organs ... Toxicology evaluation revealed a fatal level of carboxyhemoglobin ...”

when inhaled. Exposure to carbon monoxide prevents red blood cells from providing oxygen to tissues”. A synopsis of the pertinent information was also done on Mr. Bayhan in the Death Investigation Summary. The cause of death for Mr. Bayhan was “...toxic effects of carbon monoxide and manner of death was accident”. The Summary and Opinion described

Mr. Bayhan as a 56-year-old man who died of carbon monoxide toxicity. “The autopsy revealed a bright red cherry discoloration of his blood, skeletal muscle and organs.” Fifty-four photographs were on the compact disc and the report of drug analysis stated Mr. Bayhan’s carbon monoxide level was 69%. [\[10\]](#)

## **VI. Relevant Law**

The Public Health Act defines “health facilities” and expressly includes boarding homes. NMSA 1978 §24-1-2 D. A health facility “shall not be operated without a license issued by the department.” §24-1-5 A. The department referenced here is the Department of Health. §24-1-2 E. When an application for such licensure is received, “the department shall promptly inspect the health facility...” §24-1-5 C.

The Department of Health (DOH) issues regulations governing facilities. However, DOH states that boarding homes are not facilities covered by the current regulation titled Assisted Living Facilities for Adults, 7.8.2 NMAC effective 01/015/2010. <sup>4</sup>

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<sup>4</sup> This regulation repealed and replaced the former regulation, entitled “Requirements for Adult Residential Care Facilities”, which did include boarding homes. See the former 7.8.2 7 Requirements for Adult Resident Care Facilities, effective 8/31/2000 at LL: “Residential Care Facility means any congregate residence, maternity shelter,



The current regulation says:

7.8.2.2 Scope: "This rule applies to all assisted living facilities, any facility which is operated for the maintenance or care of two (2) or more adults who need or desire assistance with one (1) or more activities of daily living.

7.8.2.7 Definitions

B. Activities of daily living (ADLs) means the personal functional activities required by a resident for continued well-being which include, but are not limited to:

- (1) eating
- (2) dressing
- (3) oral hygiene
- (4) bathing
- (5) grooming
- (6) mobility, and
- (7) toileting...

J. "Assistance" means prompting, encouragement, or hands-on help with the activities of daily living by another person.

K. "Assistance with medication" means support provided to residents to assist them with medication delivery by non-licensed or non-certified paid staff and does not allow for the assessment of the effects of the medication.

Mrs. Encinias described the assistance she provided for individuals in her boarding home, which included meal preparation, making their beds, prompting them to clean their living quarters, taking them to appointments, prompting them to dress, filling their prescriptions and providing assistance with medication.

The Adult Protective Services Act defines among other things, abuse, neglect and covered facilities. It also defines "provider" as a "private-residence or health care worker or an unlicensed residential or nonresidential entity that provides personal, custodial or health care". NMSA 1978 §27-7-16, Definitions. Individuals who live in boarding homes are covered by the Act, if not as people living in facilities, then as individuals who receive services through a "provider". *Id.*

The Long Term Care Ombudsman Act created an office to help individuals living in a variety of long term care facilities, assert their civil and human rights. NMSA 1978 §27-17-1 et seq. Boarding homes are facilities expressly covered by the Act as a "Long Term Care" facility means any residential facility that provides long-term care services to one or more persons unrelated to the owner or operator of the facility, including, but not limited to those facilities enumerated

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or building for adults which provides and whose primary purpose is to provide to the residents, within the facility, either directly or through contract services, programmatic services, room, board, assistance with the activities of daily living, in accordance with the program narrative and/or general supervision to two (2) or more adults who have difficulty living independently or managing their own affairs." See also footnote 6, below at page 17.

in NMSA 1978 § 28-17-3(F) (which includes boarding homes), §27-17-3 N. Generally, facilities covered by the Ombudsman must display information providing contact information for the Ombudsman's office.

The Long Term Care Services Act, NMSA 24-17A-1, et seq. was enacted to direct relevant state agencies to create a comprehensive statewide home and community based service delivery system. Consumers who live in boarding homes appear to be individuals living in the kinds of residences covered by the Act. NMSA § 24-17A-2.

The Human Services Department has the authority to provide social services to adults. NMSA 1978, §9-8-13. This authority includes administering and supervising these social services which may include prescribing regulations, and inspecting and requiring reports from boarding homes that provide "assistance, care or other direct services to the disabled."

## **VII. Conclusions**

Mr. Montoya and Mr. Bayhan lived in circumstances for which there was no oversight, ultimately causing their deaths. Mr. Encinias is charged with neglect of a resident resulting in death, a second degree felony and a jury trial is scheduled for December 9, 2014.<sup>5</sup> However, the circumstances of their deaths point to far broader problems. First, there is a dearth of appropriate housing, both supportive and independent, for individuals with serious mental illness.

Second, there is no systemic oversight of boarding homes such as the one in which these men resided and died. In 2010, the Department of Health repealed regulations entitled "Requirements for Adult Residential Care Facilities", the former 7.8.2 NMAC (effective 8.31.2000) and replaced them with regulations called "Assisted Living Facilities for Adults", 7.8.2 NMAC (effective 1.15.2010). DOH's stated position to DRNM and others is that boarding homes are not covered under the newest regulations.<sup>6</sup> It is clear that the services provided to Mr. Montoya and Mr. Bayhan were the kinds of assistance described in current regulation that would trigger applicability of the regulation. 7.8.2 NMAC. Mrs. Encinias gave each man his medications per instructions from NMBHI/CBS; she took the prescriptions from NMBHI/CBS, called the pharmacy, and stored the medications at her residence. She took them to medical appointments, prepared their meals and snacks, made their beds, reminded them to go to bed, and told them when to put on their pajamas. Whether by prompting or actually taking care of an activity of daily living, the Encinias Boarding Home was engaged in providing assistance with

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<sup>5</sup> Fourth Judicial District Court, D-412 CR 201400120

<sup>6</sup> Boarding Home Committee Meeting Convened by the Department of Health, October 3, 2014, statement of Elizabeth Trickey, Office of General Counsel.

two or more activities of daily living as described in the “Assisted Living for Adults” regulations. As Mrs. Encinias said in her statement to the State Police, “It’s not landlord tenant.”

The former regulation also enabled the Aging and Long Term Services Department’s Ombudsman program to provide assistance to boarding home residents; NMSA 1978 section 28-17-3(F) (which includes boarding homes). That office advocated for boarding home resident rights, investigated residents’ complaints and helped resolve concerns the resident may have had. If necessary, they would work with Adult Protective Services to assure the safety of an individual. § 28-17-9. When 7.8.2 NMAC was repealed and replaced, it was no longer clear that the Ombudsman’s office had jurisdiction in boarding homes because there was no longer an authority regulating boarding homes to which reports could be made. The Ombudsman’s office is concerned that these homes are unregulated.<sup>7</sup> It is DRNM’s experience that boarding home residents rarely have access to an Ombudsman due to this ambiguity.

Apparently, the Department of Health is **required** to license boarding homes, §24-1-2 D, and the Human Services Department has the authority to regulate them. § 9-8-13 A (4). Further, the Aging and Long Term Services Department has an office expressly charged with advocating for the civil and human rights of persons living in boarding homes, §28-17-2, and is charged with investigating allegations of abuse or neglect of adults living in boarding homes, or by a provider giving personal or custodial care, when the Adult Protective Services Division receive such reports. §27-7-16.

In short, three state agencies have jurisdiction over boarding homes or places providing personal or custodial care to adults with serious mental illness, but none of them are providing systemic oversight to these kinds of residences.

Until there are other housing options, individuals with serious mental illness will continue to be relegated to these living situations. To protect their health, safety and general welfare, there must be some systemic oversight.

## **VIII. Recommendations**

As a general matter DRNM recommends that the Department of Health meet its statutory obligation to license and inspect boarding homes, and that all relevant state agencies exercise their authority so as to protect the health and safety of boarding home residents. At a more specific and immediate level, DRNM makes the following recommendations:

1. At minimum, any home that houses two or more individuals and provides personal, custodial or health care NMSA 1978 §27-7-16, should be inspected by a municipal or county fire marshal.

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<sup>7</sup> Boarding Home Minutes, meeting convened by DOH, May 13, 2014, statement of Sondra Everhart, Ombudsman.

2. Boarding homes should be considered businesses subject to business license requirements.
3. Residences housing two or more adults who need or desire assistance with one or more activity of daily living – such as the boarding home in which Mr. Montoya and Mr. Bayhan died - should be considered Assisted Living Facilities for Adults and regulated as such by DOH. 7.8.2.1 NMAC.
4. A boarding home should have a grievance procedure.
5. Residents in boarding homes should have access to the state’s Long Term Care Ombudsman’s office. Each boarding home should post information providing contact information to the Ombudsman’s office in a conspicuous location.
6. NMBHI and other hospitals that discharge individuals to boarding homes should require documentation that the boarding home meets minimum health and safety standards to accept people as clients. Such documentation should include a fire marshal inspection certificate or certificate of compliance with Dwelling Sanitation and Safety codes.
7. NMBHI and other hospitals should review their discharge policies to include assurances that any placements, such as boarding homes, are safe and habitable.
8. Boarding homes should have a rental agreement with each resident so the resident can be protected by the Uniform Owner-Resident Relations Act, NMSA 1978 47-8-1, et seq.
9. Guardians or representative payees have fiduciary duties to the individuals they serve. The guardian should sign or co-sign the rental agreement and attest that he or she has visited the residence and believes it is a safe and habitable place as defined in the Uniform Owner-Resident Relations Act. Although a representative payee cannot sign a lease, he or she has the fiduciary responsibility for assuring the money is spent for the intended reason. Representative payees should at minimum be required to obtain a copy of the lease or rental agreement for that purpose. See this web site for guidance to such payees: [www.ssa.gov/payee/faqrep.htm](http://www.ssa.gov/payee/faqrep.htm) (last visited 11.24.14)
10. If an individual has a treatment guardian, the facility discharging that individual needs to inform the treatment guardian of the individual’s discharge and location. In this way, the treatment guardian can visit the home if s/he chooses, though there is no legal obligation to do so.
11. Any person receiving care in a psychiatric hospital should be screened for Medicaid eligibility and provided assistance as needed to apply. If found eligible, he or she should be enrolled in Medicaid and one of the MCOs while still in the hospital. Then, the MCO should immediately assign a care coordinator to assist with discharge planning and level II or level III care coordination, as appropriate.
12. The Long Term Care Services Act, NMSA 24-17-1, et seq, enacted to direct relevant state agencies to create a comprehensive statewide home and community based service delivery system, should be amended to expressly include living situations such as boarding homes.
13. New Mexico needs to more aggressively develop supportive housing for people with chronic and persistent mental illness who will need long term assistance or interim living assistance before they can live more independently. Medicaid and other funding sources should be explored for potential support for this kind of housing.

## **IX. References**

1. Salazar, Martin. "2 boarding home tenants found dead" Las Vegas Optic, October 29, 2013.
2. Salazar, Martin. "Details emerge in deaths" Las Vegas Optic, November 5, 2013.
3. Salazar, Martin. "Couple charged in deaths" Las Vegas Optic, April 1, 2014.
4. Interview of Superior Ambulance Services Employee Cecelia Payan by Agent Mark Alsfeld, New Mexico State Police Investigations Bureau.
5. Report by Agent Mark Alsfeld, New Mexico State Police Investigations Bureau. Supplemental date 12/9/13
6. Supplemental Report by Officer Nelson Leyba, December 23, 2013.
7. Supplemental Report by Agent Ryan Boone, State Police Investigations Bureau, October 28, 2013
8. Supplemental Report by Sergeant Clay Goret, dated January 15, 2014
9. Code Violation Determination reports, New Mexico Construction Industries Division, October 31, 2013
10. Death Investigation Summaries for Mr. Montoya and Mr. Bayhan, dated November 26, 2013