STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325105	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Taos Healthcare	1340 Maestas Road Taos, NM 87571

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to promote residents' choices for 2 (R #4 and #5) of 2 (R #4 and #5) residents reviewed for choices when staff placed a bladder control pad (products made for incontinence control to pull moisture away from your skin) in the briefs of residents. These deficient practices are likely to result in the resident's personal choices, needs, and preferences not being honored. The findings are: A. On 05/09/24 at 2:58 pm during an interview with an anonymous former staff member, they stated Certified Nursing Assistants (CNAs) sometimes put a bladder control pad in the resident's brief so it did not leak. The former staff stated residents wear bladder control pads in their briefs a lot, because the CNAs did not want to change the residents as often. The former staff also stated CNAs would utilize the bladder control pads without asking for the residents' permission sometimes. B. On 05/10/24 at 10:24 am during an interview with CNA #2, she stated the facility did not use double briefs (wearing two briefs at the same time). She stated they used a bladder control pad in the resident's brief when the resident had a lot of urine or diarrhea, because it was a protector for the brief. CNA #2 also stated she asked residents if she could add a bladder control pad to their brief, but she was unsure if any other staff asked before they used the pads. C. On 05/10/24 at 10:40 am during an interview with CNA #3, he stated he did not use bladder control pads, but he saw other CNAs use them. He stated the CNAs put the bladder control pads on residents, and the pads are designed to prevent the residents from getting urine all over the bed. D. On 05/10/24 at 11:07 am during an interview with Registered Nurse (RN) #1, she stated she was not familiar with a bladder control pad. RN #1 stated she was unaware that CNAs used bladder control pads in residents' briefs. E. On 05/10/24 at 12:56 pm during an interview with the Director of Nursing (DON), she stated she did not know why the facility had bladder control pads. She stated she has never seen the bladder control pads. The DON stated staff may have ordered the bladder control pads by mistake. The DON stated the CNAs should just use one brief on the residents. The DON stated CNAs should not use bladder control pads in addition to briefs for residents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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Taos Healthcare	1340 Maestas Road Taos, NM 87571

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 05/10/24 at 2:08 pm during an interview with CNA #4, he stated that he has multiple residents that wear a brief, but he does not use bladder control pads in resident's briefs. CNA #4 stated he used a mattress protector pad instead for resident comfort. G. On 05/10/24 at 2:13 pm during an interview with CNA #1, he stated he used bladder control pads inside the briefs for residents who urinate a lot to prevent leaking from the brief. CNA #1 stated R #5 currently wore a bladder control pad in her brief. R #5: H. Record review of R #5's face sheet revealed R #5 was admitted into the facility on [DATE] with the following diagnoses: 1. Hemiplegia (one-sided paralysis) and Hemiparesis (weakness of half of the body) following a stroke affecting right side, 2. Need for assistance with personal care, 3. Aphasia [a comprehension and communication disorder (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain]. I. Record review of R #5's care plan, dated 05/08/24, revealed the following: - Focus: R #5 had bladder incontinence related to impaired cognition and mobility. - Interventions: Encourage fluids during the day to promote prompted voiding responses. Incontinent: Check as required for incontinence. Wash, rinse and dry perineum J. On 05/10/24 at 2:57 pm during an interview with R #5, she stated she did not like when CNAs put the bladder control pad in her brief, because it did not feel good. She said sometimes it took the staff a while to change her soiled brief. R #5 stated she told the nursing staff before that she did not like to wear bladder control pads in her brief. R #5 also stated she was currently wearing a bladder control pad in her brief. R #4: K. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE] with the following diagnoses: 1. Anoxic brain damage (occurs when the brain is deprived of oxygen), 2. Aphasia. L. Record review of R #4's care plan, dated 04/19/24, revealed the following: - Focus: R #4 had bladder incontinence related to impaired mobility and poor cognition. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Interventions: Encourage fluids during the day to promote prompted voiding responses. Incontinent: Check as required for incontinence. Wash, rinse and dry perineum (the area between the anus and the scrotum or vulva). Change clothing as needed (PRN) after incontinence episodes. M. On 05/10/24 at 2:33 pm during an interview, R #4 nodded his head Yes to indicate the CNAs put a bladder control pad in his brief. R #4 shook his head No and grimaced to indicate he did not like having the bladder control pads placed in his brief. R #4 was unable to state which staff he told that he did not like wearing the bladder control pads, but R #4 nodded his head Yes to indicate he told staff he did not like wearing bladder control pads in his brief.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview, the facility failed to revise the care plan for 1 (R #1) of 3 (R #1, 2, 3) residents reviewed for falls. If the facility is not updating the care plan to reflect the resident's current care needs and treatments, then the facility may not be providing the appropriate care to meet the resident's needs. The findings are: A. Record review of R #1's face sheet revealed he was admitted to the facility on [DATE] with multiple diagnoses to include: - Urinary tract infection. - Personal history of transient ischemic attack (small minor stroke of unknown cause with short duration). - Cerebral infarction (a blood vessel located in the brain that is blocked reducing or stopping blood flow to that area) without residual deficits (no lasting effects). - Unspecified fall. - Cognitive communication deficit (inability to effectively speak with and understand others). B. Record review of R #1's daily care notes revealed staff documented the following: - On 10/04/23, a Certified Nurses Aide (CNA) found R #1 sitting on the floor in front of bed. No injuries noted. - On 10/07/23, Interdisciplinary Team (IDT; a group of individuals with varied professional skills that meet to discuss resident concerns and treatments) note: IDT reviewed R #1's care plan focus, goals, and interventions for increased safety and decreased risk for major injury. Staff to monitor more frequently. - On 10/26/23, R #1 found on the floor on stomach, stated he fell , and did not have injuries noted upon assessment. Staff obtained the resident's neurological's (a measure of a persons nervous system response by observation of eye/pupil responses, facial strength, speech patterns, muscle strength of legs and arms and ability to walk and maintain balance) and vitals (measure of a persons blood pressure, heart rate, breathing rate and body temperature). Care and monitoring continued. - On 10/29/23, IDT note: IDT reviewed R #1's care plan focus, goals, and interventions for increased safety and decreased risk for major injury. Staff to monitor more frequently. - On 11/17/23, R #1 found sitting on the floor next to his bed, denied pain, denied hitting head. Staff obtained the resident's neurological's and vitals. Staff notified the Medical Doctor (MD), Director of Nursing (DON), and family of the incident. Care and monitoring continued. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 11/20/23, IDT note IDT reviewed R #1's care plan focus, goals, and interventions for increased safety and decreased risk for major injury. Staff to monitor more frequently. - On 12/04/23, CNA found R #1 on the floor on floor near bathroom with wheelchair nearby and reported to Registered Nurse (RN). CNA and RN picked R #1 up off floor after the RN assessed R #1 for range of motion (ROM; the ability to move limbs about without pain or discomfort), pain, and fractures (broken bones). R #1 stated he was trying to walk to bathroom. - On 12/09/23, a visitor who was walking down the hall observed R #1 on the floor in his room. The visitor alerted the nurse who went to R #1's room to assess the resident. R #1 had full ROM of all four extremities (both legs and both arms) and denied pain. Staff notified the MD and made the family aware of the incident. - On 12/11/23, IDT note: IDT reviewed R #1's care plan focus, goals, and interventions for increased safety and decreased risk for major injury. Staff to monitor more frequently. - On 12/11/23, R #1 was found lying on the floor of his room, on his back, in front of his walker. R #1 denied pain and was able to move all four extremities. Staff notified the MD, DON, and family notified. - On 12/11/23, IDT note: Intervention to have Physical Therapy (PT) evaluate and treat R #1. The resident to use his walker during ambulation and to remember to call for help. Staff to monitor more frequently. - On 12/14/23, IDT note: Intervention to have PT evaluate and treat R #1. The resident to use his walker during ambulation and to remember to call for help. Staff to monitor more frequently. - On 12/22/23, Change of condition noted regarding falls. Staff did not document any other description of the change of condition. - On 12/22/23, IDT note: staff educated R #1 on safety awareness and need to use call light. - On 12/25/23, IDT note: R #1 to have PT continue to treat, to teach the importance of locking his wheelchair before sitting or standing, to use walker during walking. Resident placed on bowel/bladder program (a program to frequently monitor and assist to bathroom). The residents current Brief Interview for Mental Status (BIMS; a simple test that provides a basic assessment of a persons basic memory abilities, scored 0 to 15, with 0 being very impaired and 15 being minimal to no impairment) was 3, severe impairment. R #1 needed to try to remember to call for help. Staff to monitor more frequently. - On 12/27/23, R #1 found on floor. Staff completed an assessment and did not find injuries. Staff notified the MD notified but could not contact family. - On 12/30/24, IDT note: Staff to monitor more frequently. - On 01/02/24, a CNA passed the resident's doorway and found R #1 sitting on floor. Staff obtained the resident's vitals, did not note any injuries, but noted redness. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 01/02/24, R #1 was very lethargic after fall. The resident's vital signs were within normal limits. Staff completed neurological's. Staff notified the MD, and the MD advised staff to send the resident to the emergency room . C. Record review of R #1's baseline care plan, dated 10/03/23, revealed the following: - R #1 was a high risk for falls. - Plan: Monitor frequently, evaluate, and treat as ordered or as needed (PRN). - Outcome: Resident will be free of major injury through the review date. - The plan did not report any recent falls and did not make changes in care needs for R #1. D. Record review of R #1's care plan, dated 05/10/24, revealed the following: - R #1 was a high risk for falls. - Approach: Monitor frequently, evaluate, and treat as ordered or PRN. - The plan did not report any recent falls and did not make changes in care needs for R #1. E. On 05/10/24 at 12:55 pm during interview, the facility Administrator (ADM) and the Director of Nursing (DON) stated R #1's care plan did not reflect his needs from 10/03/23 to 01/03/24. They stated they could not explain why his care plan for falls was dated 05/10/24, except that someone must have reviewed the care plan and caused the date of the plan to change to the current date. The ADM stated the care plan did not provide any updates or interventions that were discussed in the IDT meetings and reported in the daily notes. The ADM stated R #1 had multiple falls during his stay in the facility. She stated staff should have reviewed each fall with the interventions and updated R #1's care plan when each fall occurred. The ADM stated the care plan was not updated and did not reflect the resident's changing needs.