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	09/26/2024

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** 46064 Based on record review and interview, the facility failed to promote resident choices for 2 (R #72 and #175) of 2 (R #72 and #175) residents reviewed for choices when staff failed to: 1. Accommodate R #72's choice to have his pacemaker (a device that stimulates the heart rate when it is beating too slowly) monitor present in the facility. 2. Offer R #175 showers per his preference. These deficient practices are likely to result in the resident's personal choices not being honored. The findings are: R #72: A. Record review of R #72's face sheet revealed R #72 was admitted on [DATE] with a diagnosis of atrial fibrillation (an irregular and often very rapid heart rhythm). B. Record review of R #72's Care Plan Conference notes, dated 09/11/24, revealed R #72 had a pacemaker (a device surgically implanted in the body to deliver electrical pulses to the heart to help the heart beat in a regular rhythm) implanted in December, 2023 and had a pacemaker monitor at home. Family will bring it in and let them know to have his name on it. C. On 09/23/24 at 1:18 PM during an interview with R #72's power of attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care)/daughter, she stated her father had a monitor for his pacemaker at home and would like it to be with him at the facility. She further stated they asked if the pacemaker monitor could be brought into the facility when her father was admitted , but staff told them to wait until a staff member contacted them. R #72's daughter stated the monitor sent a report to the doctor's office daily. She stated if her father had heart issues then the doctor would see it and call them. She stated the monitor also notified them if the pacemaker worked incorrectly. (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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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 09/26/24 at 7:35 PM during interview with the Director of Nursing (DON), she stated R #72 should have his monitor in the facility if that was what he wanted. She further stated the monitor had important information on who to call if something happened to the pacemaker. The DON stated it was important to have the pacemaker monitor, because the monitor tracked if the resident's heart started to beat slowly. 41988 R #175: E. Record review of R #175's face sheet revealed R #175 was admitted to the facility on [DATE] and discharged on [DATE]. F. Record review of R #175's care plan revealed the following: - Dated 09/23/23: Focus: Resident's family stated a shower preference three times a week. Interventions: Offer resident a shower three times a week and as needed (PRN). - Dated 03/22/24: Focus: Resident has an ADL self care performance deficit. Interventions: R #175 is totally dependent on two staff to provide bath and showers. G. Record review of R #175's concern/grievance reports revealed the following: - On 04/08/24: Grievance filed by R #175's spouse and stated the resident did not receive a shower on Sunday, Monday, or today. - On 06/26/24: Grievance filed by R #175's spouse and stated R #175 was not bathed on 06/26/24 and 06/27/24. Grievance also stated, Getting him [R #175] showers on a regular basis is an ongoing challenge. H. Record review of R #175's documentation survey report (Activities of Daily Living- ADL tracking form), dated 06/14/24 through 06/30/24, revealed staff did not offer and give R #175 any baths or showers out of six opportunities. Staff did not document the resident refused any baths or showers during the month. I. Record review of R #175's shower sheets, dated 06/14/24 through 06/30/24, revealed the facility did not provide any shower sheets for R #175. J. Record review of R #175's documentation survey report, dated 07/01/24 through 07/31/24, revealed staff offered and gave R #175 four baths or showers out of 14 opportunities. Staff did not document the resident refused any baths or showers during the month. K. Record review of R #175's shower sheets, dated 07/01/24 through 07/31/24, revealed staff offered and gave R #175 five baths or showers out of 14 opportunities. L. Record review of R #175's documentation survey report, dated 08/01/24 through 08/30/24, revealed staff offered and gave R #175 eight baths or showers out of 13 opportunities. Staff did not document the resident refused any baths or showers during the month. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. Record review of R #175's shower sheets, dated 08/01/24 through 08/30/24, revealed staff offered and gave R #175 10 baths or showers out of 13 opportunities. R #175 refused two baths/showers for the month. N. On 09/25/24 at 1:14 pm during an interview with Licensed Practical Nurse (LPN) #2, she stated she remembered R #175 missed showers when he was in the facility, and he and his family complained about that. O. On 09/25/24 at 3:31 pm during an interview with Certified Nursing Assistant (CNA) #1, she stated R #175 would not refuse baths or showers, and he liked a bath or shower three times a week. P. On 09/25/24 at 3:59 pm during an interview with CNA #2, she stated R #175 enjoyed taking baths or showers, but he frequently did not get three baths or showers a week. Q. On 09/26/24 at 1:47 pm during an interview with the Director of Nursing (DON), she stated R #175 and his family wanted R #175 to be offered and given three showers a week. She stated staff should have done that, but they did not.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to prevent an accident for 1 (R #75) of 1 (R #75) residents reviewed for falls: 1. When the facility failed to routinely assess R #75 to check for injuries following the first fall. 2. When the facility failed to follow post-fall protocols after R #75's first and second falls. These deficient practices likely resulted in R #75 having falls with injuries that required treatment at the hospital. The findings are: A. Record review of the facility's Response to Fall policy, undated, revealed guidance for staff regarding post-fall assessment and monitoring: Following each resident fall, the licensed nurse to complete an incident report and perform a post-fall assessment and investigation. B. Record review of the facility's neurological assessment policy, dated 02/2019, revealed nursing staff should complete a neurological assessment after a resident fall as follows: - Every 30 minutes four times; - Every hour four times; - Every four hours four times; - Every shift; - Combined total of 72 hours. C. Record review of R #75's face sheet revealed R #75 was admitted into the facility on [DATE] and was discharged to the hospital on 09/06/24. D. Record review of R #75's care plan, dated 10/30/23, revealed the following: - Focus: R #75 was at risk for falls related to spastic movement (disruption in muscle movement patterns) and muscle weakness. He ambulated (to move from place to place) by wheelchair only, was not always aware of his own limitations, and had episodes of incontinence (loss of bladder or bowel control). He had a history of refusing help at times as evident by diagnoses of cerebral palsy (group of disorders that affect movement, muscle tone, balance, and posture) and muscle disorder. His fall risk assessment was high risk. - Interventions: Give R #75 reminders as needed not to transfer or ambulate without assistance. Falls to be reviewed by the fall team (Nursing, therapy). May implement new interventions beyond routine interventions to reduce risk of potential injury to resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. Record review of R #75's nursing progress notes, dated 09/05/24 at 7:33 am, revealed R #75 yelled out during morning care. The resident was frustrated, because no one understood him when he verbalized his needs. Resident stated he needed someone to listen to him who understood English. F. Record review of R #75's nursing progress notes, dated 09/06/24 at 4:36 pm, revealed R #75 experienced an unwitnessed fall, and the bridge of his nose remained red after the fall. (This indicated R #75 potentially hit his face during the fall.) G. Record review of R #75's assessments tab located in the Electronic Health Record (EHR) revealed staff did not complete post-fall neurological assessments for R #75 after the resident's first fall on 09/06/24 at 4:36 pm. H. Record review of R #75's nursing progress notes, dated 09/06/24 at 6:06 pm, revealed R #75 experienced a second fall that re-opened a laceration above his left eye, but R #75 denied pain. Provider, Administrator (ADM), and Director of Nursing (DON) were notified. I. Record review of R #75's assessments page located in the EHR revealed nursing staff completed one neurological assessment for R #75 after the resident's fall on 09/06/24 at 6:10 pm. J. Record review of R #75's nursing progress notes, dated 09/06/24 at 7:30 pm, revealed R #75 experienced a third fall, and R #75 stated his neck hurt. R #75 was sent to the emergency room (ER) after the third fall. K. Record review of R #75's nursing progress notes, dated 09/06/24 at 10:10 pm, revealed the facility was notified by the hospital that R #75 experienced a neck fracture located in C1 and C2 (first two vertebrae located at the top of cervical spine). L. On 09/25/24 at 11:04 am during an interview with R #75's Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care), she stated R #75 experienced three falls on 09/06/24, and the third fall resulted in R #75's neck fracture. R #75's POA stated R #75 was out of it since he experienced the fracture. M. On 09/25/24 at 11:13 am during an observation of R #75, he lay in bed sleeping and wore a cervical collar (neck brace used to support the neck and spine). N. On 09/25/24 at 1:17 pm during an interview with Licensed Practical Nurse (LPN) #2, she stated R #75 experienced three falls on 09/06/24, which resulted in R #75 fracturing his neck after the third fall. LPN #2 also stated she assessed R #75 after the first two falls, but she was not there when R #75 fell for the third time that day. LPN #2 stated a post-fall neurological assessment should have been completed every 15 to 30 minutes after a resident falls. LPN #2 stated R #75 will often try an assist himself with a self transfer, because he gets mad that he cannot communicate to the staff. O. On 09/26/24 at 3:42 pm during an interview with LPN #1, he stated R #75 had a tendency to self-transfer, and staff knew to keep an eye on him. LPN #1 stated nursing staff will immediately complete a post-fall neurological assessment when a resident falls. He stated they will send the resident to the ER right away if they have a head or face injury, even if the resident denied pain. LPN #1 stated post-fall neurological assessments should be completed for 72 hours, with the initial assessments occurring every 15 minutes during the first few hours and the intervals increasing as time passes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P. On 09/26/24 at 7:32 pm during an interview with the DON, she stated the nursing staff should have assessed R #75 every 15 minutes, then every 30 minutes, and then every two hours after the first fall on 09/26/24. The DON stated staff did not complete post-fall neurological assessments as frequently as they should have for R #75 after his first and second falls on 09/06/24.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41988 Based on record reviews and interviews, the facility failed to ensure the facility had sufficient staff to meet the needs of all 77 residents who resided in the facility when staff failed to: 1. Offer baths or showers to residents as scheduled and per resident preference. 2. Effectively communicate with residents to meet their needs. These deficient practices are likely to negatively impact resident comfort. The findings are: Resident Baths and Showers: A. Refer to F561 and F677 for related findings. B. On 09/25/24 at 1:23 pm during an interview with an anonymous staff member (ASM), they stated the facility did not have enough staff which resulted in resident baths or showers being missed often. C. On 09/25/24 at 3:34 pm during an interview with CNA #1, she stated sometimes the facility will experience short staffing, and resident baths and showers get missed when that happens. D. On 09/25/24 at 4:02 pm during an interview with CNA #2, she stated there was not enough staff to clean up resident beds and give residents baths and showers. CNA #2 also stated there is not any staff to respond to call lights when the CNAs need two people to assist a a resident with a bath or shower, due to low staffing. Communicate to Meet the Needs of Residents: E. Record review of R #75's nursing progress notes, dated 09/05/24 at 7:33 am, revealed R #75 yelled out during morning care. The resident was frustrated, because no one understood him when he verbalized his needs. Resident stated he needed someone to listen to him who understood English. F. On 09/23/24 at 3:15 pm during an interview with R #37, she stated sometimes the staff did not speak English to her during care, and she did not understand them. G. On 09/24/24 at 1:44 pm during an interview with the anonymous staff member (ASM), they stated multiple residents and staff have complained, because they were unable to communicate with CNAs and nursing staff. H. On 09/25/24 at 3:37 pm during an interview with CNA #1, CNA #1 stated she can understand English, but she has a difficult time speaking English. CNA #1 required a translator during this interview. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	I. On 09/25/24 at 4:04 pm during an interview with CNA #2, she stated she can understand a little English, but she needed the assistance of a translator to communicate with residents and staff. CNA #2 required a translator during this interview. J. On 09/25/24 at 9:48 am during an interview with the Administrator (ADM), she stated the majority of the staff was able to communicate with each resident, but not the entire facility. The ADM also stated the nursing staff that was not able to communicate with a resident should get a translator to assist as soon as possible to ensure care was not delayed.