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	12/04/2024

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

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34439 46064 Based on record review and interview, the facility failed to give written notice for a room change, including the reason for the change, before the residents were moved for 2 (R #1 and R #3) of 2 (R #1 and R #3) residents. This deficient practice is likely to result in frustration and confusion for residents. The findings are: Findings for R #1: A. Record review of R #1's face sheet, dated 11/25/24, revealed the following: - admitted [DATE]. - Other drug induced secondary Parkinsonism (symptoms that may occur due to the side effects of taking certain medications.) - Dementia, mild, with other behavioral disturbance (a disease that causes loss of memory, language, problem-solving and other thinking abilities.) - Disorganized schizophrenia (a mental disorder characterized by speech, emotional expressions, thoughts, and actions that are disorganized or not in tune with what is expected or appropriate.) - Cognitive communication deficit (difficulty understanding and speaking with other people.) - Other symptoms and signs involving cognitive functions and awareness. B. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 9/17/24, revealed R #1 had a Brief Interview for Mental Status (BIMS; a screening tool used to assess cognition) score of 6, severe cognitive impairment. C. Record review of R #1's electronic medical record (EMR) revealed R #1 was moved from the [NAME] Unit to the [NAME] Unit on 09/27/24. The record did not contain notes to show the facility notified the resident's family. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 12/04/24 at 10:16 am during an interview, R #1's daughter stated she was not made aware that R #1 was going to be moved to another unit. She stated she found out he moved when she went to visit him and was unable to locate him in his room. She stated his room on the [NAME] Unit was empty of all personal belongings, and staff told her that he was now residing on the [NAME] Unit. R #1's daughter stated she would have expected the facility to notify her of R #1's move. Findings for R #3: E. On 12/04/24 at 9:50 am during an interview with R #3, she stated she moved rooms, and she was not notified of the room change. R #3 stated she wondered why they moved her when she did not want to be moved. R #3 stated all her clothing and belongings were not move into her new room, and she did not know where her personal belongings were being kept. F. On 12/04/24 at 10:01 during an interview, Certified Nurse Aide (CNA) #3 confirmed R #3 was moved to the [NAME] Unit and prior to the move the resident was on the [NAME] Unit. CNA #3 stated R #3 was moved, because her room was being painted. The CNA stated she was not sure if staff notified R #3 that she was moving to a new room and why. CNA #3 stated R #3's belongings remained in her old room. G. On 12/04/24 at 12:15 pm during an interview with the Director of Nursing (DON), she stated the protocol was to notify housekeeping, dining services, and nurses station when moving residents from one room to another and to document the move in the resident's medical record. The DON stated staff should also notify the resident's family, and that should also be documented in the medical record. The DON was unable to provide any documentation for R #1's or R #3's room change. H. On 12/04/24 at 12:20 pm during an interview with the Administrator, she stated R #3's room change was temporary, because staff were painting her room. The Administrator stated the facility will let the families and the resident know a couple of days in advance that their loved one was going to be moved to another room. The Administrator was unable to provide any documentation as to when staff notified R #1 and R #3 of the room changes or that staff notified the residents' family members.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064 Based on record review and interview, the facility failed to notify the Providers (Physicians and Nurse Practitioners) of a change in condition in which a resident began to have behaviors for 1 (R #1) of 1 (R #1) residents reviewed for change of condition. If the physician is not notified of changes in residents status then residents are likely to not get the care needed. The findings are: A. Record review of R #1's face sheet, dated 11/25/24, revealed the following: - admitted [DATE]. - Other drug induced secondary Parkinsonism (symptoms that may occur due to the side effects of taking certain medications.) - Dementia In other diseases classified elsewhere, mild, with other behavioral disturbance (a disease that causes loss of memory, language, problem-solving and other thinking abilities.) - Disorganized schizophrenia (a mental disorder characterized by speech, emotional expressions, thoughts, and actions that are disorganized or not in tune with what is expected or appropriate.) - Cognitive communication deficit (difficulty understanding and speaking with other people.) - Other symptoms and signs involving cognitive (how people think) functions and awareness. B. Record review of R #1's care plan, dated 09/12/24, revealed the following: - R #1 had a behavior problem related to schizophrenia, with no problems listed, no interventions and no goals. - R #1 had a potential communication problem related to not always being able to communicate clearly and related to Parkinson's (a condition that effects muscle control, balance and movement) diagnosis. - R #1 had impaired cognitive function related to his diagnosis of dementia. C. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 09/17/24, revealed staff documented R #1 did not have any behaviors exhibited to include physical behavioral symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Record review of R #1's behavior charting, dated 10/24/24, revealed R #1 tried to encourage a female resident to come to his room or he tried to enter their rooms. Resident held hands with female residents and kissed their hands. Interventions attempted: Reminded resident he may not touch other resident without their permission, he may not enter female resident rooms without their permission, and he may not encourage female residents to come to his room. Effectiveness of the interventions: Resident will remember in the moment but needed to be redirected and reminded on a regular basis. E. Record review of R #1's Nursing progress notes, dated 10/29/24 , revealed R #1 tried to touch a resident in an inappropriate manner, touching, and wanting to kiss. R #1's one-to-one sitter stopped the resident and redirected him to room. Resident was inappropriate with others last week. Review of progress notes in R #1's medical record did not indicate R #1's physician had been notified of R #1's behaviors. F. On 11/27/24 at 12:41 PM during an interview with MD #1, she stated the expectation was for the facility to notify her when there were resident behaviors. MD #1 stated she did not expect staff to notify her of a one time incident, but she did expect them to call her if it was an ongoing behavior. She stated she expected staff to notify her so they could have a discussion and see what other interventions need to be implemented. MD #1 stated one-to-one supervision was appropriate for R #1's behavior. MD #1 stated the facility did not notify her regarding R #1's behaviors, but htey should have. G. On 12/4/24 at 11:10 AM during an interview with the Director of Nursing (DON), she stated R #1's record did not contain any documentation regarding communication with the provider.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46064 Based on record review and interview, the facility failed to complete and document a thorough investigation had been done for 1 (R #1) of 2 (R #1 and #8) residents reviewed for an allegation of abuse. If the facility fails to complete thorough investigations residents are likely to feel frustrated and unsafe. The findings are: R #1 and R #8 A. Record review of the facility's Follow Up Report to the State Agency, dated 10/29/24 at 5:19 pm, revealed the following: 1. R #1 was in the dining room with R #8 and waited for meal service. 2. Both residents held hands and kissed each other's hands. 3. R #1 leaned in and kissed R #8 on the lips as R #8's husband entered the dining room. 4. R #8's husband became upset and alerted staff to what happened. B. Record review of R #1's behavior charting, dated 10/24/24, revealed R #1 tried to encourage a female resident to come to his room or he tried to enter their rooms. Resident held hands with female residents and kissed their hands. Interventions attempted: Reminded resident he may not touch other resident without their permission, he may not enter female resident rooms without their permission, and he may not encourage female residents to come to his room. Effectiveness of the interventions: Resident will remember in the moment but needed to be redirected and reminded on a regular basis. C. Record review of R #1's nursing progress notes, dated 10/29/24, revealed R #1 tried to touch a resident in an inappropriate manner, touching, and wanting to kiss. R #1's one-to-one sitter stopped the resident and redirected him to room. Resident was inappropriate with others last week. D. Record review of Administrator (ADM) note for R #1, dated 10/29/24 at 2:35 pm, revealed the ADM spoke to R #1's daughter on 10/29/24, and the daughter stated she would come get R #1 and take him home. E. On 12/4/24 at 11:30 AM during an interview with the Administrator, she stated she filed the report based on the statements made by R #8's husband. She did not verify if other residents or staff witnessed the incident and she did not investigate if the incident occurred. The ADM stated she should have done a better job at documenting the incident. The ADM confirmed she went solely off the statement that R #8's husband provided, because he was so upset. The ADM stated R #8 discharged home on 11/15/24 after the incident. The ADM stated the incident happened in the dining room during mealtime on 10/24/24. The Administrator did not provide any documentation regarding investigations into R #1's behaviors noted on 10/24/24 and 10/29/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 12/02/24 at 12:19 pm during an interview with Registered Nurse (RN) #1, he stated he remembered R #1 was caught twice being inappropriate with the ladies. The RN stated one incident was at the nurses station. He stated R #8's husband said R #1 kissed his wife on the cheek while the husband was with her. RN #1 stated R #8's husband was upset and told R #1 he could not do that. RN #1 stated R #8 was not upset, because she had dementia (disease that causes loss of memory, language, problem-solving and other thinking abilities.) RN #1 stated R #8's husband took her home. RN #1 stated the other incident was in the dining room with another resident, but he was not sure what happened since he did not witness the incident. RN #1 stated R #1 was discharged for inappropriate behaviors, because he needed one-to-one staffing.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064 Based on record review and interview, the facility failed to include required information in the residents medical record for transfer or discharge for 1 (R #1) of 1 (R #1) residents reviewed for discharges. This deficient practice is likely to result in resident and residents family being unable to locate an appropriate placement putting the residents at risk of an unsafe discharge. The findings are: A. Record review of R #1's face sheet, dated 11/25/24, revealed the following: - admitted [DATE]. - Other drug induced secondary Parkinsonism (symptoms that may occur due to the side effects of taking certain medications.) - Dementia In other diseases classified elsewhere, mild, with other behavioral disturbance (a disease that causes loss of memory, language, problem-solving and other thinking abilities.) - Disorganized schizophrenia (a mental disorder characterized by speech, emotional expressions, thoughts, and actions that are disorganized or not in tune with what is expected or appropriate.) - Cognitive communication deficit (difficulty understanding and speaking with other people.) - Other symptoms and signs involving cognitive (how people think) functions and awareness. B. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 9/17/24, revealed R #1 did not display physical or verbal behaviors toward others. C. Record review of R #1's Recapitulation of Stay Resident Discharge Summary, dated 10/29/24, revealed the resident was discharged home per administration's discretion. There was no other documentation in R #1's medical record identifying behaviors prior to the discharge MDS dated [DATE]. D. Record review of R #1's discharge MDS dated [DATE] revealed under section E, Question E0200/ A. - Physical behavior symptoms directed toward others (e.g., hitting, kicking, scratching, grabbing, abusing others sexually) Answer- Behavior of this type occurred 1 to 3 days. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. On 11/25/24 at 11:37 AM during interview with R #1's daughter/Power of Attorney (POA), she stated the Administrator (ADM) called her on 10/29/24. The daughter stated the Administrator said her father was being transferred to a facility in Colorado, because the facility could not provide a one-to-one (staff member providing support, care,or supervision specifically to one individual) sitter for her father due to sexual behaviors. The daughter stated the ADM told her that was the facility's final decision, and he would be transferred. The daughter stated the facility did not provide a 30 day discharge letter to her or her father, and it would have been nice to have that time to find another place for her father. The daughter went to pick up her father, because she felt had no other choice. She stated, she [Administrator] forced me. The daughter stated she felt overwhelmed and feared her father would be transferred without her knowledge since the ADM looked for another place for him without her consent. The ADM began looking for another facility and sending referrals on 10/24/24 the date of the incident in the dining room when the husband was upset. F. On 11/25/24 at 4:22 pm during an interview with the Director of Nursing (DON), she stated there were concerns about R #1 kissing another man's wife. He [R #1] touched other residents and held hands with residents in the dining room. The DON stated R #1 had dementia. The DON stated the facility tried for two days to get a hold of the daughter to let her know what was going on with her father. The DON stated they asked R #1's daughter what she wanted to do, and she asked for a referral to another facility. The DON stated they had R #1 on a one-to-one, and staff kept an eye on him. One on one care started on 10/24/24 and ended on 10/29/24 when R #1 discharged . The DON stated they informed the daughter the facility was not able to continue the one-to-one staff with her father because the facility was not staffed for that kind of care. She stated the facility started looking at other options, and they found a couple facilities for the resident. One referral was in Southern New Mexico and the other in Colorado. The daughter was informed and communicated to the facility that she did not want her father transferred to Colorado or to the Southern part of New Mexico. The DON stated she had several conversations with the resident and the daughter, but she did not document any of the conversation. The DON stated she was not able to verify when those conversation occurred. G. On 11/25/24 at 4:22 pm during an interview with the ADM, she stated she had concerns about R #1's behaviors of kissing and touching other residents. The ADM stated she had conversations with the facility's Regional staff about discharging R #1. The ADM stated they did not give R #1 or R #1's family a 30 day notice, because R #1's daughter came and picked him up. The ADM stated she did not document any of the conversations with the daughter, and she did not document any conversations or recommendations that were made by the facility's Regional staff or R #1's daughter. The ADM stated she should have documented the conversations. ADM was aware of the behaviors going on with R #1, but she had not documented the issues. R #1 was on a 1:1 staffing for approximately 5 days prior to leaving the facility. ADM stated that the facility was unable to provide the care needed to for R #1 (1:1 staffing) and were looking for alternate placement and had communicated that with R #1's daughter. Daughter came and picked R #1 up and took him home, after the discussion of having him moved to another facility. ADM also confirmed that no other interventions had been put into place other then 1:1 staffing and no discharge plan had been documented. ADM felt that there was no other choice but to transfer to another facility or to be discharged with daughter home.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 34439 Based on record review, observation, and interview, the facility failed to ensure 3 (R #5, #6 and #7) of 3 (R #5, #6 and #7) residents reviewed had a working portable concentrator. This deficient practice is likely to have a resident become hypoxic (having too little oxygen in the blood). The findings are: R #5 A. Record review of physicians orders for R #5, dated 12/16/23, revealed oxygen (O2) administered at 2 liters per minute (LPM) continuous per nasal cannula (a medical device that consists of a small, flexible tube with two prongs that sit inside a patient's nostrils), face mask, or facial tent via O2 concentrator or tank. B. On 11/25/24 at 12:15 pm during an observation, Certified Nurse Aide (CNA) #1 checked R #5's portable O2 concentrator and stated there was not any oxygen coming out of the concentrator and not functioning. CNA #1 asked Minimum Data Set (MDS) Director #1 to check R #5's oxygen saturations, and R #5's oxygen saturation measured 82 percent (%; ideal oxygen saturations 95% to 100%). CNA #1 and MDS director were unsure as to how long R #5's concentrator had not been working. CNA #1 further stated that O2 concentrator should be checked before taking residents to the dining room and throughout the day. C. On 11/25/24 at 12:16 during an interview, R #5 stated he had trouble breathing and could not confirm how long it had been that he was having trouble breathing. R #6 D. Record review of physicians orders for R #6, dated 11/03/23, revealed oxygen at 1 to 4 LPM per nasal cannula via O2 concentrator or tank. E. On 11/25/24 at 12:17 pm during an observation, CNA #1 checked R #6's O2 concentrator and stated there was not any oxygen coming out of the portable concentrator. CNA #1 checked R #6's O2 level, and the oximeter (a device that measures your blood oxygen levels and pulse) was unable to read R #6's O2 level. CNA #1 left to locate a working portable O2 concentrator. F. On 11/25/24 at 12:19 pm during an observation and interview, MDS Director #1 checked the oxygen saturation for R #6 and stated he was a little cyanotic (bluish-purple color of the skin due to deficient oxygenation of the blood). This observation was also observed by the surveyor. The MDS Director proceed to ask R #6 to take deep breaths. The MDS Director confirmed R #6's portable oxygen was not working. R #6 was unable to answer the MDS Director when she asked him if he was having trouble breathing. R #6 was confused and unable to communicate effectively. R #6 appeared to be lethargic (a state of reduced activity and mental alertness) and not very responsive when aide was trying to assist him in eating his meal. MDS Director stated he was less alert than usual. R #7 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. Record review of R #7's physicians orders, dated 10/23/24, revealed 4 liters per nasal cannula continuously. H. On 11/25/24 at 12:20 pm during an observation and interview, CNA #1 checked R #7's oxygen concentrator and stated there was not any oxygen coming out of the portable concentrator. CNA #1 checked R #7's oxygen level and was not able to get a reading. MDS #1 asked R #7 to take a deep breath and was able to get a reading. The resident's oxygen saturation measured 89%. MDS #1 stated all the oxygen concentrators should be in working order and able to deliver the ordered amount of oxygen needed. MDS #1 stated the oxygen concentrators for R #5, R #6, and R #7 were not working . I. On 11/25/24 at 7:30 pm during a phone interview with an anonymous caller stated that the portable oxygen concentrator for R #5, #6, and #7 did not work and they let the Director of Nursing know. The caller stated the DON did not do anything about it. J. On 12/04/24 at 10:39 am during an interview with CNA #1, he stated all resident should have working O2 concentrator, and they should be getting the oxygen that was ordered. K. On 12/04/24 at 12:15 pm during an interview with the Director of Nursing, she stated her expectation was that all residents had working O2 concentrators. DON stated all portable concentrator are checked throughout the day by the CNA's. Vitals which include checking oxygen levels is done twice a day and as needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34439 Based on interview, record review, and an observation of the [NAME] Unit, the facility failed to ensure a medication cart remained locked when not in use. This deficient practice is likely to result in residents having access to the medications in the unlocked medication cart. The findings are: A. Record review of the facility's Security of Medication Cart Policy, dated April 2007, revealed medication carts must be securely locked at all times when out of the nurse's view. B. On 12/02/24 at 12:18 pm during an observation of the [NAME] Unit, the medication cart was unlocked and unattended. Further observation revealed nursing personnel were not present, and residents walked around and sat close to the unlocked medication cart. C. On 12/02/24 at 12:19 pm during an interview with Registered Nurse (RN) #1, he confirmed the medication cart should be locked at all times when not in use. RN #1 further stated he stepped away to assist another resident and was aware he should have locked the cart.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34439 Based on record review, observation, and interview, the facility failed to store and serve food under sanitary conditions when staff failed to: 1. Ensure opened food items in the refrigerator, freezer, and dry storage room were dated and labeled. 2. Ensure staff utilized a sanitizing solution when cleaning various food related surfaces. 3. Ensure eggs and cheese were stored in a manner to prevent food borne pathogen growth when not in the refrigerator. 4. Ensure all storage areas are kept clean and free of debris. 5. Ensure kitchen staff wore their face mask appropriately. These deficient practices are likely to affect all 85 residents listed on the resident census list and are likely lead to foodborne illnesses if food is not being stored properly and safe food handling practices are not adhered to. The findings are: A. On 12/05/24 at 8:40 am, an observation of the facility kitchen revealed the following: - Eight eggs and a small package of sliced cheese sat on a cart next to the kitchen stove. The eggs and cheese sat for one hour and were not on ice. The eggs were warm to touch, and the cheese started to change color. - The Dietary Aide cleaned food service areas and counter tops with the same dish cloth. The Dietary Aide did not use a sanitizing solution between wiping the different surfaces. - A tray of glasses with an unidentified orange liquid sat on the top shelf of the refrigerator unlabled and undated. - A bag of cut red onions were in the refrigerator, losing their form, turning liquidy, and were unlabeled and undated. - A bag of round pastries were in the refrigerator and open to air, - A bag of unidentified items were in the refrigerator and open to air. - The dry storage room floor had dirt and debris under the food shelves. - The water wells on the steam table had calcium build-up and food particles. (continued on next page)

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	12/04/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- A tray containing five salads were in the facility refrigerator unlabeled and undated. B. On 11/25/24 at 1:45 pm during interview, Dietary Aide (DA) #2 confirmed there was a bag of unidentified substance in the refrigerator, and it was not dated. He also confirmed there were five tossed salads not dated in kitchen refrigerator. C. On 11/25/24 at 4:40 pm during an interview with the DM, he confirmed all the above findings. He stated staff could not clean the wells in steam table any better. Facemasks D. On 11/25/24 at 1:40 pm during observation, DA #1 wore his mask below his nose on chin while helping prepare food in the facility kitchen, DA #1 stated it should be covering his nose and not on his chin. He confirmed that all staff are required to wear masks at all times while in the facility due to a respiratory virus outbreak in the building. E. On 11/25/24 at 4:40 pm during an interview with the DM, he stated staff should always were face masks appropriately and at all times while in the facility.