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Form Approved OMB
No. 0938-0391

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46064 Based on observation, record review, and interview, the facility failed to promote care with dignity and respect for 1 (R #19) of 1 (R #19) residents reviewed for residents' rights by placing a WanderGuard (a bracelet that sets off an alarm when the person wearing it attempts to exit the building) on a resident who did not attempt to leave the facility grounds. This deficient practice is likely to result in residents feeling as if they were kept in the facility against their will. The findings are: A. On 9/22/24 at 5:12 PM during a random observation, R #19 wore a wander guard. B. Record review of R #19's physicians orders revealed the resident did not have an order for a wander guard. C. Record review of #19's care plan, dated 07/25/24, revealed staff did not care plan the resident's wander guard. D. Record review of R #19's Elopement Risk Evaluation, dated 7/25/24, revealed the following: - Score of 6, moderate risk; - No Risk section: If yes to question A1 or A2, the assessment is complete. - Section A1: Resident was able to make decisions regarding task of daily living? Staff answered no. - Section A2: Resident was unable to ambulate or mobilize wheelchairs? Staff answered yes. - Moderate Risk section: Resident was cognitive impaired and staff entered the following information: - Resident ambulated or propelled self; - Resident may go outdoors on occasion but did not make an attempt to leave grounds. - Action: Implement Elopement Risk Care Plan. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Imminent Risk section: Staff did not enter any information. - Additional Information section: Care Plan. - Focus: Resident was at risk for elopement related to Elopement Evaluation risk score. - Approach: Discuss and educate resident/family regarding risk of elopement and addition risk reduction strategies. Engage resident in activities of choice. Report to the doctor risk factors for potential elopement. Supervise closely and make regular compliance rounds whenever resident was in room. - The section did not contain any information regarding a wander guard. E. On 09/26/24 at 2:08 PM during an interview with Director of Nursing (DON), she stated R #19 says she was going home every day, but the resident was easily redirected. The DON stated R #19 did not attempt to leave the building, but the resident wore a wander guard as a preventative measure. F. On 09/26/24 at 7:32 PM during an interview with Regional Registered Nurse (RRN), she stated R #19 was not a risk for elopement, and staff should reassess R #19. The RRN stated if the resident was not an elopement risk then she should not wear a wander guard.

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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. 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]. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 46064 Based on interview, the facility failed to ensure residents received mail on Saturdays for all 77 residents who resided at the facility. This deficient practice is likely to result in residents not receiving timely communication which could result in feelings of isolation. The findings are: A. On 09/24/24 at 1:15 PM during the Resident Council meeting, the residents stated staff did not deliver mail to them on the weekends, but they thought staff should. B. On 09/26/24 at 9:06 AM during an interview with the Activities Director, she stated staff did not deliver mail on the weekends to the residents. She stated if the Post Office delivered mail to the front office on the weekend, then staff put it in the activities mail box for her to deliver on Monday. C. On 09/26/24 at 2:16 PM during an interview with the Administrator, she stated the expectation was for residents to get their mail on the weekends if that was when the Post Office delivered it to the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41988 Based on observation, record review, and interview, the facility failed to ensure staff revised the care plan for 4 (R #19, #39, #71, and #72) of 4 (R #19, #39, #71, and #72) residents reviewed when staff failed to: 1. Update the care plan to include a wander guard (wearable technology used to keep residents from wandering or eloping from the facility unattended) use for R #19 and #39. 2. Update the care plan to include family assistance with activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) care for R #71. 3. Update the care plan to include the use of a fall mat for R #72. These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: R #19: A. On 9/22/24 at 5:12 PM during a random observation, R #19 wore a wander guard. B. Record review of R #19's care plan, dated 07/25/24, revealed staff did not care plan R #19's use of a wander guard. C. On 09/26/24 at 7:06 pm during an interview with the Director of Nursing (DON), she confirmed R # 19 wore a wander guard. She further stated staff did not care plan R #19's wander guard, but they should have. R #39: D. Record review of R #39's face sheet revealed R #39 was admitted into the facility on [DATE]. E. Record review of R #39's physician orders, dated 09/09/24, revealed an order for a wander guard. F. Record review of R #39's care plan, dated 09/24/24, revealed R #39 was at risk for elopement related to impaired safety awareness, but the use of a wander guard was not present in the care plan. G. On 09/26/24 at 7:06 pm during an interview with the DON, she stated staff did not care plan R #19's wander guard, but they should have. The DON confirmed R #39 wore a wander guard device. R #71: H. Record review of R #71's face sheet revealed R #71 was admitted into the facility on [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Record review of R #71's shower sheet, dated 09/10/24, revealed R #71 wanted to wait for her sister to bathe her. J. Record review of R #71's care plan, dated 09/18/24, revealed R #71 required ADL care assistance related to decreased mobility. R #71 required partial assistance while bathing, but the resident's care plan did not indicate R #71's family provided assistance with bathing. K. On 09/23/24 at 11:29 am during an interview with R #71, she stated her sister helped her take baths or showers per her preference. L. On 09/25/24 at 3:31 pm during an interview with Certified Nursing Assistant (CNA) #1, she stated R #71 preferred to be assisted with bathing by her sister. M. On 09/26/24 at 2:31 pm during an interview with Licensed Practical Nurse (LPN) #3, she stated R #71 stated not like staff to bathe her and preferred for her sister to help her. LPN #3 stated the facility nursing staff were aware of this. N. On 09/26/24 at 2:35 pm during an interview with the DON, she stated staff should care plan that R #71 preferred her sister's assistance with bathing, but they did not. 46064 R #72: O. Record review of R #72's face sheet revealed the resident was admitted on [DATE] with the following diagnoses: - Atrial fibrillation (an irregular and often very rapid heart rhythm), - Metabolic encephalopathy (change in how your brain works due to an underlying condition), - Unspecified dementia (when confusion or mild cognitive impairment cannot be clearly diagnosed as a specific type of dementia), - Spinal stenosis (narrowing of the space surrounding the spinal cord causing pressure and pain), cervical region, - Acute kidney failure (when your kidneys stop working suddenly), - Benign prostatic hyperplasia (a non-cancerous increase in size of the prostate gland). P. On 09/23/24 at 2:00 PM, during an observation and interview, a fall mat lay in front of R #72's bed. The resident stated the fall mat was put there after one of his falls. Q. On 09/23/24 at 2:58 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), she stated she was concerned because her father had a couple of falls since his admission. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R. Record review of R #72's progress notes revealed the resident had a fall without injury on 9/11/24 and a fall with injury on 9/18/24. He was sent to the emergency room for x-rays and a computed tomography (CT scan; an imaging test that allows doctors to see inside your body with more detail than a regular X-ray) The resident returned to the facility on the same day. The CT scan results returned with no findings (nothing on the scan that is urgent, needs quick treatment, or is life threatening) . S. Record review of R #72's care plan revealed staff did not care plan the resident's fall mat. T. On 09/26/24 at 2:16 PM during an interview with the Director of Nursing (DON), she stated R #72 had a couple of falls since admission, but he did not have any injuries. She stated staff did not care plan the resident fall mat, but they should have.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance for baths and showers by the facility staff for 1 (R #58) of 1 (R #58) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: A. Record review of R #58's face sheet revealed R #58 was admitted into the facility on [DATE]. B. Record review of R #58's care plan, dated 03/05/24, revealed the following: - Focus: R #58 had an ADL self-care deficit related to a history of fractures. - Interventions: Shower at least once a week and as needed. - R #58 was dependent on staff for bathing. C. Record review of the facility's bath and shower schedule revealed R #58 was scheduled to bathe or shower on Wednesdays and Saturdays. D. Record review of R #58's documentation survey report (Activities of Daily Living - ADL tracking form), dated 08/01/24 through 08/31/24, revealed staff offered and gave R #58 nine baths or showers out of nine opportunities. E. Record review of R #58's shower sheets, dated 08/01/24 through 08/31/24, revealed staff offered and gave R #58 four baths or showers out of nine opportunities. F. Record review of R #58's documentation survey report, dated 09/01/24 through 09/26/24, revealed staff offered and gave R #58 twelve baths or showers out of six opportunities. G. Record review of R #58's shower sheets, dated 09/01/24 through 09/26/24, revealed staff offered and gave R #58 four baths or showers out of six opportunities. H. On 09/23/24 at 9:58 am during an interview with R #58, she stated staff told her there was not enough staff to bathe her, and her baths and showers have significantly reduced. R #58 also stated she would take a bath or shower once a day if they would let her. I. On 09/25/24 at 3:34 pm during an interview with CNA #1, she stated R #58 did not refuse baths or showers, and R #58 wanted a bath or shower every day. CNA #1 also stated staff document baths and showers on the shower sheets and nowhere else. CNA #1 confirmed R #58 missed showers due to staffing issues. J. On 09/25/24 at 4:31 pm during an interview with Certified Medication Aide (CMA) #1, he stated R #58 liked to take a lot of baths and showers, and she would take one every day if she could. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	K. On 09/26/24 at 1:49 pm during an interview with the Director of Nursing (DON), she stated resident's baths and showers should be documented on shower sheets and in the electronic health record. The DON confirmed staff did not offer and give R #58 enough baths and showers.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to provide restorative physical therapy service devices as recommended by the therapy department for 1 (R #37) of 1 (R #37) residents. This deficient practice is likely to result in residents having pain and a decrease in mobility, causing psychosocial harm and despair. The findings are: A. Record review of R #37's face sheet revealed R #37 was admitted into the facility on [DATE] with the following diagnoses: 1. Encephalopathy (a disease that affects brain structure or function and causes altered mental state and confusion). 2. Muscle weakness. 3. Quadriplegia (paralysis of all four limbs). B. Record review of R #37's care plan, dated 06/23/23, revealed R #37 required assistance to meet basic activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) care due to quadriplegia to include assistance with transfers and ensuring R #37's call light was in reach for use. C. Record review of R #37's Occupational Therapy (OT) assessment summary, dated 07/09/24, revealed R #37 would benefit from upper extremity (arms) and neck passive range of motion (movement caused when an outside force, such as a therapist causes movement of a joint) restorative nursing program. D. On 09/23/24 at 3:22 pm during an observation and interview with R #37, she lay in bed with her head positioned near her left shoulder and visible contractures (muscle tightening deformity that makes flexibility and movement difficult) of both of hands. R #37 stated she thought she was supposed to receive range of motion exercises from the nursing staff. She stated she did not receive it, but she would like to. E. On 09/25/24 at 1:14 pm during an interview with Licensed Practical Nurse (LPN) #2, she stated the facility used to have a restorative nursing aide, but they did not have one anymore. LPN #2 stated she did not see therapy or therapy services offered to R #37 in awhile. F. On 09/25/24 at 3:59 pm during an interview with Certified Nursing Assistant (CNA) #2, she stated she did not offer range of motion or restorative nursing services to R #37. G. On 09/25/24 at 4:27 pm during an interview with Certified Medication Aide (CMA) #1, he stated the facility used to have a restorative nursing aide, but they did not have one now. H. On 09/26/24 at 2:37 pm during an interview with the Director of Rehabilitation (DOR), she stated R #37 would benefit from range of motion therapy and restorative nursing, but the facility did not offer those services. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47091 Based on observation, interview, and record review, the facility failed to ensure that ileostomy [a surgical procedure in which the last part of the small intestine (ileum) is connected to the abdominal wall and an opening (stoma) is created in the abdominal wall to allow waste to leave the body] care was consistent with professional standards of practice for 1 (R #13) of 1 (R #13) resident when the ostomy bag and the abdominal binder (wide compression belt that encircles the abdomen) was not consistently offered/applied per physician order. This deficient practice could likely result in skin breakdown/infection around the ostomy opening. The findings are: A. Record review of R #13''s face sheet revealed she was admitted to the facility on [DATE]. B. Record review of R #13's physician's orders revealed the following: 1. Dated 12/21/23, change ileostomy bag per wound orders. When resident refused ostomy (ileostomy) bag or continually removed bag, cleanse skin surrounding ostomy two times per shift daily. Cleanse with saline and apply barrier cream to areas of erythema (redness) and excoriation (skin breakdowns) surrounding stoma. Apply abdominal pad over stoma and barrier cream to protect skin from stool. 2. Dated 12/21/23, ostomy care: Reinforce the need to always keep ostomy bag in place. Crusting and pasting technique: With each application of new ostomy bag, cleanse peristomal area define with mild soap and water and pat dry. Spray No-Sting Skin Prep to peristomal area. Lightly apply stoma powder to peristomal area, lightly dust. Wait one minute in between application, then repeat. Repeat process at series of three times and end with No-Sting Prep spray. Apply ostomy bag and duoderm thin to secure. 3. Dated 01/25/24, clean stoma and surrounding area. Use stoma skin barrier. Place loose abdominal binder around waist with sewn on tubes or buttons to distract resident. C. Record review of R #13's Care Plan, dated 06/29/23, revealed the following: 1. R #13 had potential for skin breakdown related to thin, fragile skin and ostomy. 2. R #13 should be checked every two hours, or more often, as needed or requested for incontinence, soiling, wetness, or any skin breakdown. D. Record review of R #13's Grievance Report, dated 09/15/23, revealed the resident felt the nursing staff did not apply the ostomy bag correctly, and the bags continued to fall off or leak. R #13 felt she never had this problem at home and wanted to change the bags herself. The DON responded that the resident repeatedly removed the ostomy bag, and staff would carry out the order [physician order for care]. E. On 9/24/24 at 2:02 pm during random observation, R #13 stood by nurses station, and the front of her pants were soiled. (continued on next page)

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

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 9/24/24 at 2:15 pm during an interview with R #13 she stated, The nurse is supposed to help me. My pants are soiled, and I have poop on my skin. I try to eat less so that it [poop] doesn't come out [points to opening of stoma]. If they [nurses] put a bag [ostomy bag; a collection bag which attaches to the stoma]. It would be better than them putting a brief over it [stoma opening]. R #13 stated confirmed that she would remove the bag when it was full or hurting. She stated it would become uncomfortable, and she would remove it. She stated she did not like to be soiled. G. On 09/24/24 at 2:16 pm during an interview with Wound Care Nurse (WCN), she stated R #13 refused to wear the ostomy bag and the abdominal pad (large wound dressing). She stated R #13 would remove the pads herself and cover the area with tissue paper. The WCN stated R #13 was referred to a Specialist for the stoma towards end of last year (2023) The WCN stated the Specialist said no to reversing the stoma and to putting the stoma in a different location on the resident's body. The WCN stated the resident had an order to change the ostomy bag twice a day. She stated the nursing staff usually changed R #13's clothing multiple times a day. H. On 09/24/24 at 2:34 pm, an observation of R #13's room and R #13's stoma care and an interview revealed the resident's bed linens and privacy curtain were soiled with urine and stool. RN #1 and the WCN provided stoma care for R #13 and confirmed the observation. Further observations revealed urine and stool ran down R #13's legs from the stoma opening. RN #1 stated the area around the resident's stoma was very red, and R #13 took Keflex (antibiotic medication used to treat skin infections) a few times due to cellulitus (a bacterial skin infection that can spread rapidly and cause serious complications) on the stoma area. Further observations revealed R #13's stoma was red, swollen, and inflamed. The skin around the stoma opening was excoriated (damaged or removed). R #13 expressed pain to the area during wound care and stated, Ouch. It burns. During observation, RN #1 or the WCN never attached or offered to attach the ostomy bag, nor was the abdominal binder applied. I. On 09/25/24 at 11:46 am during an interview with LPN #1, he stated R #13 often removed her ostomy dressing. He stated the staff continually checked on the resident to ensure she did not remove the dressing. LPN #1 stated staff will clean the stoma and check the ostomy if they observe R #13 try to remove the dressing. He further stated R #13 had a history of skin infection in the stoma area, but R #13 did not have a current infection. J. On 09/26/24 at 2:26 pm during an interview with the Director of Nursing (DON), she stated the staff should attempt to apply an ostomy bag, and they should apply the abdominal pad (binder) if R #13 removed the ostomy bag. The DON stated she was aware R #13 expressed pain to the stoma, and staff did not attempt new interventions to keep R #13 from removing the wound dressing.

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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.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to ensure 2 (R #12 and #62) of 2 (R #12 and #62) residents reviewed for behavioral health concerns received necessary behavioral health care to meet their needs when staff failed to ensure effective communication between the facility and psychiatric providers and provide consistent psychiatric services to meet R #12 and #62 psychiatric service needs. These deficient practices are likely to result in the residents not receiving the behavioral or mental health care and assistance needed to improve mood and reduce depression and anxiety. The findings are: R #12: A. Record review of R #12's face sheet revealed R #12 was admitted into the facility on [DATE]. B. Record review of R #12's care plan, dated 09/15/22, revealed R #12 had a diagnoses of depression, and facility staff should monitor R #12 for any signs of depression. C. Record review of R #12's nursing progress notes, dated 07/13/24, revealed Psychiatric Services Provider (PSP) #1 saw R #12 for medication management. Further review of the progress notes revealed PSP #1 did not see R #12 after that date. D. Record review of R #12's nursing progress notes, dated 08/15/24, revealed R #12's Patient Health Questionnaire (PHQ) 2 Evaluation (a screening tool used to diagnose depression) stated R #12 was feeling down, depressed, or hopeless for two to six days. E. On 09/23/24 at 1:10 pm during an interview with R #12, he stated he experienced depression. He stated he has not been able to talk to someone about that, but he would like to. F. On 09/25/24 at 11:18 am during an interview with the Social Services Director (SSD), she stated R #12 would benefit from psychiatric talk therapy services, and she did not know why R #12 saw the psychiatric service provider. G. On 09/26/24 at 6:18 pm during an interview with PSP #1, she stated they did not offer talk therapy services to residents in the facility. She stated they visit the residents for psychiatric medication management when needed and not on a regular basis. PSP #1 also stated she assessed each resident she visited, but she did not follow-up with them often or on a regular basis. R #62: H. Record review of R #62's face sheet revealed R #62 was admitted into the facility on [DATE]. I. Record review of R #62's care plan, dated 03/05/24, revealed R #62 was diagnosed with depression, and staff should assist R #62 in developing more appropriate methods of coping. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. Record review of R #62's nursing progress notes, dated 08/23/24, revealed R #62's PHQ 2 Evaluation stated R #62 was feeling down, depressed, or hopeless for two to six days. K. Record review of R #62's nursing progress notes, dated 09/07/24, revealed PSP #1 saw R #62 for medication management. Further review of the progress notes revealed, The patient reports feeling sad, difficulty sleeping, lack of appetite, loss of interest, and is evasive when asked about suicidal thoughts .Plan: Continue bupropion [medication used to treat depression], continue to monitor for increased signs of depression/anxiety, and encourage the patient to participate in group activities. The progress notes did not reveal if talk therapy was offered to the resident. L. On 09/23/24 at 1:29 pm during an observation and interview, R #62 lay in bed and stared at the ceiling. The resident was not interested in conversation and had an overall sad, depressed attitude while he talked. R #62 stated he had a lot of depression, and the facility did not offer him any talk therapy to help with that. R #62 also stated, It's easier to watch a person die than it is to be that person dying. M. On 09/24/24 at 11:23 am during an interview with the SSD, she stated R #62 had depression that was getting worse for the past three weeks. The SSD also stated R #62 would benefit from talk therapy services, but she was unaware of what psychiatric services were offered to R #62.

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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. 47031 Based on observation, interview, and record review, the facility failed to maintain the kitchen in a sanitary manner when staff failed to: - Store food in a manner that prevented cross contamination when staff did not label and date open food items. - Utilize hair restraints and beard guards in a manner which restrained all hair while in the kitchen. - Test the sanitizer level in a sanitizing bucket. - Failure to store ice scoop appropriately. These failures have the potential to result in cross contamination, the growth of foodborne pathogens, and foodborne illness. This failure had the potential to affect all residents who ate food from the kitchen. The findings are: Unlabeled and Undated Food Items: A. On 09/22/24 at 3:55 pm, observation of the Dietary Department refrigerators and freezers revealed the following: - One 6 ounce (oz) bowl of ice cream not labeled or dated. - One tray of 16 glasses of 8 oz. clear liquid not labeled or dated. - One 5 pound (lb) bag of radishes open to air, not dated. - One tray of unidentified food not labeled or dated. - One tray of 6 oz. glasses of yellow liquid not labeled or dated. - One zip lock bag of sliced lunch meat open to air, not labeled or dated. - One 5 lb. bag of ground beef, bulk roll was not dated and sat directly on open shelving without a drip pan - One foam plate of unknown food items not labeled or dated. - One tray of 6 oz. glasses of liquid not labeled or dated. - Six plastic 6 oz. bowls of orange sections not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. On 09/22/24 at 3:55 pm during an interview with the Dietary Manager (DM), he stated all food items should be labeled, dated and protected from air. Hair Restraints C. On 09/22/24 at 3:45 pm during an observation of the kitchen, Dietary Aide (DA) #1 did not wear a hairnet while in the kitchen. Dietary Aide's #1 hair measured over 1 in length. D. On 09/22/24 at 3:45 pm during an observation of the kitchen, DA #2 did not wear a hairnet or a beard guard to restrain his hair while in the kitchen. DA #2's hair measured over 1 in length on head and face. E. On 09/22/24 at 3:55 pm during an interview with the Dietary Manager (DM), he stated all Dietary Staff should wear hair nets and beard guards to restrain all their hair while in the kitchen. Sanitizing Buckets F. On 9/22/24 at 3:46 pm during random observation of kitchen, a sanitizing bucket sat on the three compartment sink. Dietary staff used the sanitizing bucket throughout meal preparation. G. On 09/22/24 at 3:50 pm during an observation and interview, DA #2 did not know how to check the strength of the sanitizing solution in the sanitizer bucket. DA #2 did not use the proper test strips to test the sanitizer in the bucket. DA #2 stated he did not perform the task before and was unaware of what the sanitizer level should be. He stated he was responsible to fill the buckets with the sanitizing solution, but he was not aware the strength of the sanitizing solution should be tested . H. On 9/22/24 at 3:50 pm during interview with Dietary Manager, he stated that all employees should know how to test sanitizing buckets. Ice Scoop Storage G. On 09/22/24 at 3:53 pm during random observation, two scoops sat unprotected on top of a dusty ice machine. Dietary staff utilized the scoops during meal preparation. H. On 09/22/24 at 3:55 pm during an interview with Dietary Manager (DM), he stated staff should store the scoops properly and not on top of the dusty ice machine.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46064 Based on record review and interview, the facility failed to ensure the Elopement Risk Evaluation was accurate for 1 (R #19) of 1 (R #19) residents reviewed when staff did not accurately complete R #19's evaluation to reflect the resident's elopement risk. This deficient practice is likely to result in resident not receiving the appropriate care and treatment he may need. The findings are: A. Record review of R #19's Elopement Risk Evaluation, dated 7/25/24, revealed the following: - Score of 6, moderate risk; - No Risk section: If yes to question A1 or A2, the assessment is complete. - Section A1: Resident was able to make decisions regarding task of daily living? Staff answered no. - Section A2: Resident was unable to ambulate or mobilize wheelchairs? Staff answered yes. - Moderate Risk section: Resident was cognitive impaired and staff entered the following information: - Resident ambulated or propelled self; - Resident may go outdoors on occasion but did not make an attempt to leave grounds. - Action: Implement Elopement Risk Care Plan. - Imminent Risk section: Staff did not enter any information. - Additional Information section: Care Plan. - Focus: Resident was at risk for elopement related to Elopement Evaluation risk score. - Approach: Discuss and educate resident/family regarding risk of elopement and addition risk reduction strategies. Engage resident in activities of choice. Report to the doctor risk factors for potential elopement. Supervise closely and make regular compliance rounds whenever the resident was in room. B. On 09/26/24 at 2:08 PM during an interview with Director of Nursing (DON), she stated R #19 says she was going home every day, but the resident was easily redirected. The DON stated R #19 did not attempt to leave the building. F. On 09/26/24 at 7:32 PM during an interview with Regional Registered Nurse, she stated R #19 was not a risk for elopement.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 47091 Based on record review and interview, the facility failed to ensure 4 (R #13, #21, #48, and #6) out of 5 residents (R #13, #21, #48, #6 and #14) reviewed for immunizations had completed and signed consent/refusal forms on file to show they consented to or declined the pneumococcal (for pneumonia, an infection in one or both lungs) and influenza (flu) vaccines. If residents are not vaccinated as appropriate against pneumonia and influenza they have a higher likelihood of contracting that illness and spreading it to other residents and staff in the facility. The findings are: A. Record review of facility's Policies and Procedures for Pneumococcal and Influenza Prevention and Control, revised on 06/2020, revealed the resident's medical record should include documentation to indicate, at minimum, the resident consented or refused vaccinations. Findings for R #13 B. Record review of R #13's immunization record revealed the resident received the flu vaccination on 09/30/23, but the medical record did not contain documentation of the provision of education regarding the benefits and potential side effects of immunizations. Findings for R #21 C. Record review of R #21's immunization record revealed the resident received the flu vaccination on 09/29/23, but the medical record did not contain documentation of the provision of education regarding the benefits and potential side effects of immunizations. Further review revealed the resident declined the pneumococcal vaccination, undated, but the medical record did not contain documentation of the provision of education regarding the benefits and potential side effects of immunizations, refusal of the immunization, or the medical contraindication of the immunization. Findings for R #48 D. Record review of R #48's immunization record revealed the resident refused the flu and pneumococcal vaccinations, undated, but the medical record did not contain documentation of the provision of education regarding the benefits and potential side effects of immunizations, refusal of the immunization, or the medical contraindication of the immunization. Findings for R # 6 E. Record review of R #6's immunization record revealed the resident received the flu vaccination on 09/29/23, but the medical record did not contain documentation of the provision of education regarding the benefits and potential side effects of immunizations. Further review revealed the resident declined the pneumococcal vaccination (undated), but the medical record did not contain documentation of the provision of education regarding the benefits and potential side effects of immunizations, refusal of the immunization, or the medical contraindication of the immunization. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 09/26/24 at 8:05 am during an interview with Infection Preventionist (IP), she stated residents sign a form to designate whether or not they want to receive the flu and pneumococcal vaccinations, and staff scan that form into the resident's medical record. She further stated it was a collaborative effort between herself and the Director of Nursing (DON). G. On 09/26/24 at 1:38 pm during an interview with DON, she stated she did not know where the residents' missing consent/refusal forms were. She stated she helped administer the vaccinations, but she did not handle the paperwork. She stated the missing consent forms should be scanned into the residents' medical records, but they were not in the records. H. On 09/26/24 at 2:59 pm during an interview with the IP and the DON, they stated the consent/refusal forms were not in the residents' medical charts, and they should be for all residents. .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41988 Based on observation and interview, the facility failed to ensure the bedroom for 1 of (R#3) of 1 (R #3) residents was clean, without food debris and used medical equipment on the floor. This deficient practice is likely to make the resident feel as if he was not important and he did not matter to the facility. The findings are: A. On 09/23/24 at 11:03 am during an observation and interview, R #3's room floor was dirty and sticky. There were food crumbs present by R #3, who sat in a wheelchair by the television, and there was an unknown yellow colored liquid on the floor next to R #3. Two of R #3's urinals lay on the nightstand, and the other one urinal lay on the floor near his bed. R #3's roommates side of the room was clean. R #3 stated the staff cleaned his room every now and then when they get a chance. R #3 stated there were times when his room was not cleaned by housekeeping staff. B. On 09/23/24 at 11:07 am during an interview with Licensed Practical Nurse (LPN) #3, she stated R #3's room was dirty and should be cleaned. LPN #3 stated she did not know why R #3's room was so dirty. She said the housekeeping staff should clean each resident's room at least one time every day, but R #3's room should not have been that dirty with multiple urinals present on the floor. C. On 09/26/24 at 2:48 pm during an interview with the Administrator (ADM), she stated the residents' rooms should be swept and mopped daily and as needed. The ADM confirmed food debris and used medical equipment should not have been left throughout R #3's room and floor.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41988 Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required in-service training of at least 12 hours per year for 2 (CNAs #3 and #4) of 5 (CNAs #3,#4, #5, #6, and #7) CNAs randomly reviewed for required in-service training. This deficient practice is likely to result in the nurses aides not receiving the necessary training to meet the care needs of the residents. The findings are: CNA #3: A. Record review of the facility staffing list revealed CNA #3 was hired on 06/17/19. B. Record review of CNA #3's annual in-service training, dated 06/17/23 through 06/17/24, revealed CNA #3 did not complete at least 12 hours of required in-service training. C. Record review of the facility staffing schedule, dated 08/01/24 through 08/31/2,4 revealed CNA #3 worked seven CNA shifts in the facility during that timeframe. D. On 09/26/24 at 3:28 pm during an interview with the Administrator (ADM), she confirmed CNA #3 did not complete the required 12 hours of in-service training but should have. CNA #4: E. Record review of the facility staffing list revealed CNA #4 was hired on 04/05/21. F. Record review of CNA #4's annual in-service training, dated 04/05/23 through 04/05/24, revealed CNA #4 did not complete at least 12 hours of required in-service training. G. Record review of the facility staffing schedule, dated 09/01/24 through 09/26/24, revealed CNA #4 worked 11 CNA shifts in the facility during that timeframe. H. On 09/26/24 at 3:29 pm during an interview with the ADM, she confirmed CNA #4 did not complete the required 12 hours of in-service training but should have.