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	01/15/2026

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on the interview and record review, the facility failed to ensure that grievances were consistently tracked, resolved, and communicated back to residents. If the facility is not responding to resident concerns, then residents may feel unimportant and this may impact their mental health as well as their physical health if residents are not receiving the appropriate meals and receiving regular showers. The findings are: A. On 01/13/2026 at 1:39 pm during a resident council meeting, the following issues were discussed: - R #107 stated residents are not being notified of how or when a grievance they have filed has been resolved. She stated grievances get turned in and they are never followed up on. She stated some of the grievances that have been filed that are waiting to be resolved are:1. Communication with kitchen staff is an issue because all kitchen staff are Spanish speaking only and they are not following resident tickets. No one from dietary attends their resident council meetings even though they have invited the dietary manager. 2. Residents have not been getting to their appointments, not sure if it's because transport department is low staffed. 3. Laundry is not being returned.4. Consistently no hot water available to residents for at least the past six months. - R #62 stated she is not getting showers because there is no hot water.- R #107 stated there is no official grievance official and she believes this is why residents are not getting a response about any resolutions.B. On 01/15/2026 at 3:00 pm during an interview, the Regional Nurse Consultant (RNC) stated the Social Services Director (SSD) or the Administrator are responsible to follow up on grievances and their process is to notify residents of grievance outcomes in person. She stated the SSD is the grievance official and it is the facility's expectation that all grievances be addressed and resolved within five working days.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure a safe, clean, and homelike environment when staff failed to:- Ensure residents consistently had access to hot water.- Maintain the dining room in a homelike manner.- Maintain resident rooms and restrooms in good repair. These failures had the potential to affect all residents who utilize the dining room and all residents in eight sampled resident rooms. If the facility does not ensure resident rooms and common areas are clean, free from pests, and maintained in good repair, then residents are at risk of decreased quality of life, pest infestation, injury due to unsafe environmental conditions, and infections due to hot water not being available. The findings are:Water TemperaturesA. On 01/11/26 at 12:26 pm during an observation in the kitchen revealed the last date water temperatures were logged was 01/07/26.B. On 01/12/2026 at 1:14 pm during an interview R #60 resident stated he had been trying to get a shower done but there was no hot water. He was informed the hot water was turned on Stated been trying to get a shower all day and night and water was cold. R #60 stated the issues with not having hot water have been going on for about 7 months and there was no hot water during Christmas. He stated he was informed that staff are turning the hot water off at night and turning back on during the day. He further stated that some elderly residents are not being showered for weeks because their showers are scheduled to be done at night. He stated he likes to shower at night, but it has been too cold, and the water doesn't heat up. He stated the facility staff told him they were going to get a new boiler because the current one always trips and shuts off.C. On 01/13/26 at 1:39 pm during an interview, R #107 stated the issues with not having hot water available have been going on for about six months. She stated there is no hot water at night so residents who are scheduled for night showers are either not receiving showers or recieving cold showers. She stated staff has advised residents to request the kitchen to boil hot water for them to wash up with. D. On 01/13/2026 at 5:15 pm during an interview, the Administrator (ADM) stated he thinks the issues with the hot water started over the past weekend. He stated the hot water temperatures should be between 90 and 108 degrees. He stated he thinks the boiler keeps tripping. The ADM further stated it was not acceptable for items to be stored in resident showers.E. On 01/13/2026 at 5:20 pm during an observation of hot water temperature in resident room [ROOM NUMBER] was reading between 80-83 degrees.F. On 01/13/2026 at 5:22 pm during an observation of hot water temperature in resident room [ROOM NUMBER] was reading between 78-80 degrees; and the faucet leaks nonstop.G. On 01/13/2026 at 5:26 pm during an observation of hot water temperature in resident room [ROOM NUMBER] was reading between 72-73 degrees; and the toilet runs nonstop.H. On 01/13/2026 at 5:31 pm during an observation of hot water temperature in resident room [ROOM NUMBER] was reading between 74-75 degrees; there were items stored in the shower.I. On 01/13/2026 at 5:35 pm during an observation of hot water temperature in resident room [ROOM NUMBER] was reading between 80-82 degrees.J. On 01/13/2026 5:39 pm during an observation of hot water temperature in resident room [ROOM NUMBER] was reading at 94 degrees.K. On 01/13/2026 at 5:42 pm during an observation of hot water temperature in resident room [ROOM NUMBER] was reading at 94 degrees.L. On 01/13/2026 5:27 pm during an interview, the Corporate Maintenance Director stated he found out about the hot water issues yesterday when he arrived at the facility. M. On 01/13/26 at 5:56 pm during an observation and interview revealed the hot water temperature for the dishwashing machine was reading at 80 degrees. The Dietary Manager (DM) stated he thinks it should be heating up to 160 degrees. Observation also revealed significant hard water build up on the outer lower part of the machine. He stated he could not find the temperature logs for the dishwashing machine.N. On 01/14/26 at 4:00 pm during an interview the DM stated kitchen staff takes the dishwashing machine water temperatures and then turns them into him (DM), and he updates the log and he had fallen behind on updating the log. He stated the logs (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should always be current.O. On 01/15/2026 at 10:19 am during an interview, CNA #3 stated residents do complain about there being no hot water for showers. CNA #3 Stated the hot water was out temporarily about a month ago. She further stated; they have to wait for a good while for there to be hot water after the dishwasher has been running. P. On 01/15/2026 at 11:55 during an interview, LPN #1 stated the water system has been giving them issues for a while; she has been told that the boiler has to be reset often.Q. On 01/15/26 at 1:05 pm during an interview, the dietitian stated it was her expectation that all kitchen logs would be up to date. Dining RoomR. On 01/11/26 at 12:42 pm an observation of the main dining room revealed there was a ceiling tile missing above the entrance to the dining room and there was exposed wiring; two ceiling tiles next to the missing tile had brown water spots on them.S. On 01/12/26 at 11:50 am, observation of the main dining room revealed there is a television set mounted on the wall that is connected to a power surge bar; the television power cord and the power surge bar were both hanging unsecured against the wall next to a resident dining table. Residents were observed to be seated at this dining table. There was also a projector screen on the same wall and the power box to it was also hanging unsecured.T. On 01/13/26 at 3:04 pm an observation of the main dining room revealed two ceiling vents located immediately over resident tables were covered with dust build up.Resident Rooms and RestroomsU. On 01/12/2026 - 01/15/26 during observations of resident rooms revealed the following:- 01/12/26 at 11:21 am, room [ROOM NUMBER] the window blinds were broken and the sink in the restroom was slow to drain.- 01/12/26 at 11:28 am, room [ROOM NUMBER] there was a sit-to-stand mechanical lift and a bedside commode stored in the shower.- 01/12/2026 at 1:10 pm, room [ROOM NUMBER] revealed there was a blood-like smear on wall next to bed B; there were no outlet covers on the outlets near the head of beds A and B; and there was a bedside commode stored in the shower.- 01/13/2026 at 5:42 pm, room [ROOM NUMBER], there was an exposed light bulb on the bottom of the wall near the doorway, the housing for the light was missing; the light fixture in the restroom was filled with dead insects.- 01/14/26 at 9:22 am, room [ROOM NUMBER], there was a bedside commode and a wheelchair stored in the shower.- 01/14/26 at 9:30 am, room [ROOM NUMBER], there were random items, including a bedside commode stored in the shower.- 01/14/26 at 9:37 am, room [ROOM NUMBER], there were random items stored in the shower.- 01/14/26 at 9:42 am, room [ROOM NUMBER], there were random items stored in the shower; and there were dead insects in the light fixture.V. On 01/15/2026 at 3:22 pm during an interview, the ADM stated the light fixtures should not be full of dead insects, there should not be an exposed light bulbs and all light fixtures should have covers, there should not be any broken or missing outlet covers, the dirty vents in dining room over resident dining tables should be clean. His expectation is that these concerns would be taken care of by maintenance, and he expects them to respond to repair requests timely.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to meet professional standards for 2 (R #'s 9 and 104) of 2 (R #'s 9 and 104) residents by: Allowing R #9 to use and store respiratory medical equipment without physician orders. Not following R #104's care plan to complete weekly skin assessments/checks. If the facility is not adhering to professional standards for quality improvement, the resident is not likely to get the highest quality of care. The findings are:R #9: A. Refer to F0880 for related findings. B. On 01/15/26 at 3:21 pm during an interview with the Regional Nurse Consultant (RNC), she stated R #9's family will bring in outside medical equipment that is not ordered. The RNC confirmed staff should be aware of what medical equipment R #9 possess and ensure there are physician orders for those devices. R #104: C. Record review of R #104's face sheet revealed R #104 was admitted into the facility on [DATE]. D. Record review of R #104's care plan dated 08/25/25 revealed R #104 was at risk for pressure ulcers (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin) related to impaired mobility and fragile skin. Staff interventions included a licensed nurse to assess R #104's skin at least weekly and report any changes. E. Record review of R #104's weekly skin check page located in the electronic health record (EHR) dated 12/01/25 through 01/15/25 revealed the following: R #104 did not receive a weekly skin assessment from 12/22/25 until 01/11/26 (three consecutive weeks). F. On 01/15/26 at 11:32 am during an interview with Licensed Practical Nurse (LPN) #1, she stated nurses are supposed to complete head to toe assessments every week. G. On 01/15/26 1:06 pm during an interview with the Wound Care Nurse (WCN), she stated R #104's wound are treated weekly by her and the wound clinic. The WCN confirmed the facility nursing staff should be completing R #104's skin assessment weekly and that did not happen. H. On 01/15/26 at 3:25 pm during an interview with the RNC, she confirmed R #104's weekly skin checks should not have been missed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and interviews, the facility failed to complete an annual performance review of Certified Nursing Assistants (CNAs) for 3 (CNAs #4, #6, and #7) of 5 (CNAs #3, #4, #5, #6, and #7) CNAs randomly reviewed. If the facility is not completing a performance review of every CNA at least once every 12 months, then residents are likely to not receive the appropriate care and services, and the CNAs may not meet the needs of all residents. The findings are: A. Record review of the facility staffing list dated 01/12/26 revealed the following: CNA #4 was hired on 10/20/17 and was still working in the facility. CNA #6 was hired on 12/01/21 and was still working in the facility. CNA #7 was hired on 10/05/22 and was still working in the facility. B. Record review of the facility CNA annual performance reviews requested on 01/14/26 revealed CNAs #4, #6, and #7 did not have annual performance reviews completed and/or available for review. C. On 01/15/26 at 1:09 pm during an interview with Registered Nurse (RN) #3, he stated he recently was put in charge of facility CNA training and annual performance reviews. RN #3 also stated each CNA is required to complete an annual performance review. D. On 01/15/26 at 3:50 pm during an interview with the Regional Nurse Consultant (RNC), she confirmed CNAs #4, #6, and #7 did not have annual performance reviews completed and should have.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews, and interviews; the facility failed to ensure medication error rate did not exceed five percent for 3 (R #16, R#26, and R #61) of 3 (R #16, R#26, and R #61) residents. The medication error rate was 11.54% from staff administering 26 medications with 3 errors. This deficient practice is likely to result in medications continuing to be administered incorrectly, increasing the risk for adverse outcomes and potential harm.The findings are:A. On 01/12/26 at 4:03 PM, during observation of medication administration, observed RN Registered Nurse (RN) #1 crush divalproex sodium (Depakote; an anticonvulsant) 500 milligrams (mg) delayed release for R #26.B. Record review of R #26 divalproex sodium 500mg delayed release medication package label does not state do not crushC. On 01/12/26 at 4:03 PM, during an interview with RN #1, she stated there is no warning on divalproex sodium label, and no indication she is unable to crush this medication.D. Record review of R #26 medication order stated Depakote Oral Tablet Delayed Release 500 MG give 1 tablet by mouth two times a day for bipolar. No notation stating to not crush medicationE. Record review of R #26, provider order shows to crush oral medications if indicated and to mix with applesauce. No order present regarding medical need to crush divalproex sodium.F. On 01/12/26 at 4:18PM, during observation of medication administration, RN #1 administering medications for R #61, Symbicort aerosol 160-4.5 micrograms (mcg)/per actuation/puff (act) inhaler (budesonide [a bronchodilator]/formoterol [a steroid]; inhaled medication to expand lungs and airway) not administered.G. On 01/12/26 at 4:18PM, during an interview with RN #1, she stated the medication is not available, and is not present in Rx Now machine (a device for storing medications) as an emergency supply. RN #1 stated she spoke with pharmacy regarding inhaler for R #61, currently awaiting delivery of medication.H. Record review on 01/12/26 at 4:25 PM, R #61 medication administration shows a total of six missed doses of Symbicort Aerosol 160-4.5 mcg/act inhaler. Missing doses are as follows;01/10/26 evening dose missed01/11/26 and 01/12/26 missed doses for morning and evening01/13/26 missed morning doseI. On 01/13/26 at 8:54AM during an observation of medication administration, observed RN #2 administered medication for R #16. Observed RN #2 crush phenytoin sodium (anticonvulsant medication to control seizures) extended-release oral capsule for administration.J. Record review of R #16 physician order dated 08/15/24 stated May crush PO medication and/or open capsules if indicated and mix with applesauce. No order present stating medical need to crush phenytoin sodium.K. Record review of R #16 physician order dated 07/13/25 revealed phenytoin sodium extended oral capsule 100mg order does not indicate any information regarding acceptability of crushing medication.L. Record review on 01/13/26 at 9:00 AM of R #16 physician order dated 07/13/25 revealed phenytoin sodium medication package label states do not crush.M. On 01/13/26 at 1:37 PM, during an interview with the Director of Nursing (DON), she stated it is her expectation staff do not crush extended/delayed release or enteric (barrier on oral medications to prevent dissolving in the acidic environment of stomach, delaying release until reaching higher pH of small intestine) coated medications. DON further stated it is the policy to not crush extended release even if it is not listed on the medication label, unless there is an order stating it would be medically necessary to crush extended release medications, such as inability to swallow, if no order present medication should not be crushed. DON stated the expectation she has for staff regarding missed medications is to take as soon as possible. If multiple days are present without the medication she is to be notified. DON stated once notified she would call pharmacy and provider to have medication or alternate delivered. DON stated there is an emergency kit for one time usage, and if medication is not present there to call pharmacy immediately as there is an agreement between their supplier for local pharmacy to obtain medication if needed quickly. DON confirmed the process was not followed for R #61's missing Symbicort Aerosol 160-4.5 mcg/act inhaler and acknowledged missed doses of medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interviews the facility failed to properly store medical supplies located in the facility medication storage room. This deficient practice is likely to result in expired medical equipment being used for resident care leading to potential infection risk, as sterility is lost over time allowing introduction of bacteria.The findings are:A. On 01/13/26 at 12:36 PM, during an observation of the 400, 500, and 600 halls' medication storage room, observed box of ReliOn Ultra Thin Lancets (small single use needles used to puncture skin to draw blood for capillary blood sugar checks) in drawer related to blood glucose checking equipment, with an expiration date of 10/2023.B. On 01/13/26 at 12:38 PM, during an interview with RN #3, he verified ReliOn Ultra Thin Lancets expired in 2023. RN #3 stated he is unaware of the policy regarding medical supply expiration dates, but stated he thinks it should be thrown outC. On 01/13/26 at 1:37 PM, during an interview with the Director of Nursing (DON), she stated it is her expectation staff does not use any expired products, all expired medications should be disposed of. DON further stated lancets should be thrown away when they are expired, otherwise they can be used for care.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure residents were served meals consistent with posted menus and food preferences were followed for 5 (R #) of 5 (R #) residents reviewed for dining when: The facility did not change nor follow the posted menus. R #22 did not receive food according to her meal ticket. R #86 was not served food according to preference. This deficient practice is likely to result in residents being unable to make informed meal choices and not receiving meals consistent with their preferences.The findings are:R #22X. Record review of R # 22's face sheet revealed R #22 was admitted to the facility on [DATE] with the diagnosis of chronic respiratory failure with hypoxia (a long-term, progressive condition where the lungs cannot adequately transfer oxygen into the bloodstream, resulting in consistently low blood oxygen levels).X. Record review of R #22's Physician Orders revealed order, dated 12/31/25, for heart health diet (limited sodium, saturated fats, trans fats, and added sugars), regular diet texture.X. On 01/12/26 at 12:00pm, during an observation of lunch, R #22'd lunch ticket revealed request for a salad in the additional notes. Further observation revealed R #22 did not have a salad with her meal.X. On 01/12/26 at 12:02pm, during an interview, R #22 stated she did not receive a salad with her lunch. R #22 stated she asked kitchen staff about her missing salad and was told they did not have a salad available for her. R #22 confirmed sje wanted a salad with her lunch.X. On 01/12/26 at 12:23pm, during an interview, Dietary Aide #1 (DA #1) stated R #22 did not receive a salad because the kitchen did not have a salad readily prepared for her.X. On 01/12/26 at 12:35pm, during an interview, the Registered Dietician (RD) stated it was her expectation the kitchen staff would have prepared and given salad to R #22 when it was requested. X. On 01/12/26 at 1:10pm, during an interview, the Dietary Manager (DM) stated it was his expectation the kitchen staff would have had a salad prepared for R #22. R #86X. Record review of R #86's face sheet revealed R #86 was admitted to the facility on [DATE] with a diagnosis of muscle wasting and atrophy (the loss of muscle tissue, resulting in reduced size, strength, and function).X. Record review of R #86's Food and Nutrition Assessment, dated 12/30/25, revealed R #86 had no known food allergies and was on a regular diet.X. On 01/12/26 at 12:04pm, during an observation of lunch, R #86's lunch ticket revealed R #86 was to be served a pork sandwich on a bun, potato salad, coleslaw, and ice cream. Further observation revealed R #86 was served mashed potatoes in place of potato salad.X. On 01/12/26 at 12:05pm, during an interview, R #86 stated items listed on food menus were often inconsistent with what was served. R #86 stated she would have preferred the potato salad shown on the menu but received mashed potatoes instead. X. On 01/15/26 at 4:08pm, during an interview with the Regional Nurse Consultant (RNC), she confirmed menus should have been updated and residents should have been served what was on the menu.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure food was stored, handled, and monitored under sanitary conditions when they failed to:Ensure food items were properly stored and protected in a manner to prevent cross contamination and outdated use.Ensure required dish machine, refrigerator, and freezer temperature daily logs were up to date.Ensure staff responsible for food safety were knowledgeable of safe food temperatures.This deficient practice could likely affect all 94 residents identified on the resident census list provided by the Administrator on 01/11/26. If food was not stored, handled, and monitored under sanitary conditions then residents are at an increased risk of contracting food born illness. The findings are:Food Storage A. On 01/11/26 at 12:26pm, an observation of the facility's kitchen revealed the refrigerator contained the following:A gallon of [NAME] Golden Italian Dressing expired 11/11/25.Two gallons of Ready Set Serve Lime Juice expired 09/29/25.A 46 fluid ounce box of Readycare Thickened Apple Juice expired 12/06/25.B. On 01/11/26 at 12:28pm, an observation of the facility's kitchen revealed the large walk-in refrigerator contained the following:Four 34-ounce containers of Dannon Low Fat Plain Yogurt expired 01/10/26.An opened package of ground meat exposed to the air.10 broken and empty eggshells stored in the same container as unbroken, unused eggs.C. On 01/11/26 at 12:30pm, an observation of the facility's kitchen revealed dry storage room contained an opened package of Nilla Wafers exposed to the air.D. On 01/14/26 at 3:50pm, an observation of the facility's kitchen revealed the large walk-in refrigerator contained six gallons of Ready Set Serve Lime Juice expired 09/24/25.Temperature LogsE. On 01/11/26 at 12:35pm, an observation of the facility's kitchen revealed PPM (Parts Per Million) dish machine maintenance, kitchen refrigerator, kitchen walk-in refrigerator, and kitchen freezer daily logs were not up to date, with last entry entered on 01/07/26.F. On 01/14/26 at 3:55pm, during an interview, the Dietary Manager (DM) stated no foods in the kitchen should be expired. DM stated it was his expectation foods would be stored properly and not exposed to air. DM stated kitchen staff gave him entries to update kitchen temperature logs and he had fallen behind in updating logs. DM stated logs should be up to date. DM stated it is the responsibility of all kitchen staff to ensure foods are properly stored, not expired, and logs are up to date. DM stated possible hazard was residents could get sick.Staff Knowledge Related to Food SafetyG. On 01/14/26 at 4:00pm, during observation and interview, dietary manager took food temperatures of items prepared for resident service and demonstrated uncertainty regarding acceptable food temperatures. Dietary manager stated he was unsure whether the temperatures obtained were safe.H. On 01/15/26 at 1:05pm, during an interview, the Registered Dietician (RD) stated it was her expectation the DM would know what the safe food temperatures were. Dietician stated it was her expectation all kitchen logs would be up to date. RD stated this was overall the responsibility of the DM and herself.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interviews the facility failed to maintain a safe and sanitary environment for 2 (R #'s 9 and 16) of 2 (R #'s 9 and 16) residents reviewed, when:R #9's respiratory spirometer (an instrument for measuring the air capacity of the lungs) and nebulizer (a medical device that delivers medication in the form of a fine mist directly into the lungs) was not stored appropriately to maintain cleanliness. The facility failed to administer a new medication for R #16 after a medication was removed from packaging which fell on top of medication cart and was placed back into medication cup by nurse. This deficient practice is likely to result in the transmission of infectious agents to the residents.The findings are: R #9: A. Record review of R #9's face sheet revealed R #9 was admitted into the facility on [DATE]. B. Record review of R #9's care plan dated 06/30/25 revealed R #9 requires oxygen (O2) use due to Chronic Obstructive Pulmonary Disease (COPD; lung disease). C. On 01/12/26 at 2:51 pm during an interview and observation of R #9, he stated he has two spirometers that he uses as well as a nebulizer for his COPD. One nebulizer and one spirometer were present on R #9's bed and not stored in a secure bag to maintain cleanliness. One other spirometer was observed to be stored on a windowsill and not stored in a secured bag to maintain cleanliness. D. On 01/12/26 at 2:53 pm during an interview with Registered Nurse (RN) #1, she confirmed R #9's two spirometers, and one nebulizer was not stored appropriately. RN #1 stated R #9's respiratory equipment should be stored in bags. E. On 01/15/26 at 1:56 pm during an interview with the Infection Preventionist (IP), she stated R #9's respiratory equipment should be labeled, dated, and stored in a bag to maintain cleanliness. R #16: F. On 01/13/26 at 8:54 AM during an observation of medication administration for R #16, observed Registered Nurse (RN) #2 preparing glucosamine (medication to assist in pain relief for osteoarthritis [chronic degeneration of the joint cartilage]) 500 mg (milligram) oral tablet for administration, removed pill from bubble packaging. Upon removal, pill missed medication cup and landed on top of medication cart. Observed RN #2 pick pill up without gloves and place medication into medication cup with other medications. G. On 01/13/26 at 8:55 AM during an interview with RN #2, she stated protocol would indicate that she should throw the pill that was on top of the medication cart away and remove a new one from the bubble package. RN #2 stated she was unsure if she had picked the medication up and placed it into the medication cup. H. On 01/13/26 at 1:37 PM during an interview with Director of Nursing (DON), DON stated regarding infection control, the expectation is for staff to perform hand hygiene between residents, and not to use same cups and supplies for multiple residents. DON also stated if a pill lands on top of the medication carts the expectation is the pill is not used. The pill is to be disposed of, and a new pill is to be removed for administration.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to maintain documentation related to staff COVID-19 (an acute respiratory infection caused by the SARS-CoV-2 virus) vaccinations that included staff were provided education regarding the benefits and potential risks associated with the COVID-19 vaccine, staff were offered the COVID-19 vaccine or information on obtaining a COVID-19 vaccine, and the COVID-19 vaccine status of staff and related information was available for all staff that work in the facility. This deficient practice could likely lead to residents contracting respiratory infections and could result in the spread of infection to other residents.The findings are: A. Record review of the facility infection control documentation/vaccinations reviewed on 01/15/25 revealed facility staff vaccination lists were not available for review. B. On 01/15/26 at 1:47 pm during an interview with the Assistant Director of Nursing (ADON) #1/Infection Preventionist (IP), she stated she does not have the facility staff COVID-19 vaccinations status list, and she does not provide education to staff regarding the COVID-19 vaccine.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure psychotropic medication (medication used to treat mental health conditions) consent forms were signed by the resident or resident representative prior to medication administration for 3 (R #'s 3, 6, and 8) of 3 (R #'s 3, 6, and 8) residents reviewed for unnecessary psychotropic drugs. This deficient practice is likely to put residents at an increased risk for undesirable side effects (including but not limited to; increased thoughts of suicide, insomnia, fatigue, sexual dysfunction) associated with the use of these medications.The findings are:R #3: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE]. B. Record review of R #3's physician orders dated October and November 2025 revealed the following: 10/08/25: Buspirone HCL (anti-anxiety medication), give 10 mg (milligrams) by mouth three times a day for anxiety. Order was discontinued on 11/04/25. 11/04/25: Buspirone HCL, give 15 mg by mouth three times a day for anxiety. Order was discontinued on 11/11/25. 11/11/25: Buspirone HCL, give 10 mg by mouth three times a day for anxiety. Order was discontinued on 11/16/25. 11/16/25: Buspirone HCL, give 15 mg by mouth three times a day for anxiety. Order was discontinued on 11/24/25. 11/24/25: Buspirone HCL, give 10 mg by mouth three times a day for anxiety. Order was discontinued on 01/02/26. C. Record review of R #3's pharmacist recommendations dated 11/05/25 revealed R #3 was prescribed the psychotropic medication Buspirone for anxiety. Pharmacist recommendation stated, Informed consent should be obtained at admission, prior to initiation of a psychotropic, or prior to increasing a dose. A consent form could not be found in in this resident's [R #3] record. The Pharmacist recommendation indicated a psychotropic medication consent form should be present in R #3's electronic health record (EHR).D. Record review of R #3's psychotropic medication consent form dated 01/12/26 revealed the consent form was for Buspirone with the order date of 11/05/25. Date and time of consent was documented as being obtained on 11/05/25 at 12:00 am. This form was created and signed on 01/12/26 (after the initial medication start date). E. On 01/15/26 at 11:32 am during an interview with Licensed Practical Nurse (LPN) #1, she stated the facility nurses will obtain a psychotropic medication order from a provider, but the Assistant Director of Nursing (ADON) #1 is responsible for completing the psychotropic medication consent form prior to medication administration. F. On 01/15/26 at 1:54 pm during an interview with the ADON #1, she confirmed R #3's psychotropic consent form for Buspirone use was not completed prior to medication administration and should have been. G. On 01/15/26 at 3:06 pm during an interview with the Regional Nurse Consultant (RNC), she confirmed R #3's psychotropic consent form for Buspirone use was not completed prior to medication administration and should have been. R #6: H. Record review of R #6's face sheet revealed R #6 was admitted into the facility on [DATE]. I. Record review of R #6's physician orders dated June 2025 revealed the following: 06/03/25: Clonidine HCL (used for anti-anxiety) 0.1 mg, give one tablet by mouth two times a day for anxiety. Order was discontinued on 06/06/25. 06/05/25: Clonidine HCL 0.1 mg, give one tablet by mouth every 12 hours as needed for anxiety. Order was discontinued on 08/07/25. 06/25/25: Ativan (Lorazepam; anti-anxiety medication) 0.5 mg, give one tablet by mouth every six hours as needed for 14 days. J. Record review of R #6's physician orders dated August 2025 revealed the following: 08/07/25: Hydroxyzine HCL (used for anti-anxiety) 25 mg, give one tablet by mouth at bedtime for anxiety. K. Record review of R #6's pharmacist recommendations dated 08/14/25 revealed R #6 was prescribed the psychotropic medications Lorazepam, Hydroxyzine, and Clonidine for anxiety. Pharmacist recommendation stated, Informed consent should be obtained at admission, prior to initiation of a psychotropic, or prior to increasing a dose. A consent form could not be found in in this resident's [R #6] record. The Pharmacist recommendation indicated a psychotropic medication consent form should be present in R #6's EHR.L. Record review of R #6's psychotropic medication consent forms dated 09/10/25 revealed the following: Lorazepam consent form was for the order (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date of 06/03/25. Date a time consent was documented as being obtained on 06/05/25 at 12:00 am. This form was created and signed on 09/10/25 (after the initial medication start date). Clonidine consent form was for the order date of 06/03/25. Date a time consent was documented as being obtained on 06/09/25 at 12:00 am. This form was created and signed on 09/10/25 (after the initial medication start date). Hydroxyzine consent form was for the order date of 06/03/25. Date a time consent was documented as being obtained on 06/09/25 at 12:00 am. This form was created and signed on 09/10/25 (after the initial medication start date). M. On 01/15/26 at 1:55 pm during an interview with the ADON #1, she confirmed R #6's psychotropic consent form for Lorazepam, Clonidine, and Hydroxyzine use was not completed prior to medication administration and should have been. N. On 01/15/26 at 3:07 pm during an interview with the RNC, she confirmed R #6's psychotropic consent form for Lorazepam, Clonidine, and Hydroxyzine use was not completed prior to medication administration and should have been. R #8: O. Record review of R #8's face sheet revealed R #8 was admitted into the facility on [DATE]. P. Record review of R #8's physician orders dated 11/06/25 revealed R #8 was prescribed Seroquel (Quetiapine, anti-anxiety) 25 mg, give one tablet via PEG-Tube (percutaneous endoscopic gastrostomy tube; a feeding tube inserted directly into the stomach through the abdominal wall to provide nutrition when oral intake is insufficient) three times a day for anxiety. Q. Record review of R #8's pharmacist recommendations dated 12/04/25 revealed R #8 was prescribed the psychotropic medication Quetiapine for anxiety. Pharmacist recommendation stated, Informed consent should be obtained at admission, prior to initiation of a psychotropic, or prior to increasing a dose. A consent form could not be found in in this resident's [R #8] record. The Pharmacist recommendation indicated a psychotropic medication consent form should be present in R #8's EHR.R. Record review of R #8's psychotropic medication consent form dated 01/12/26 revealed the consent form was for Quetiapine with the order date of 11/07/25. Date and time of consent was documented as being obtained on 11/07/25 at 12:00 am. This form was created and signed on 01/12/26 (after the initial medication start date). S. On 01/15/26 at 1:56 pm during an interview with the ADON #1, she confirmed R #8's psychotropic consent form for Quetiapine use was not completed prior to medication administration and should have been. T. On 01/15/26 at 3:08 pm during an interview with the RNC, she confirmed R #8's psychotropic consent form for Quetiapine use was not completed prior to medication administration and should have been.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from abuse for 1 (R #25) of 1 (R #25) resident reviewed, when:Facility nursing staff used threatening language via text messages to R #25 while on approved facility leave. A facility nurse inappropriately touched R #25's foot when he returned to the facility after approved facility leave. If the facility performs inappropriate use of text messaging and touching, then residents are at risk for physical injury and psychological harm, including fear or distress related to staff interactions. The findings are:^ A. Record review of R #25's face sheet revealed R #25 was admitted into the facility on [DATE]. B. Record review of R #25's nursing progress notes dated 12/28/25 revealed the following: 12/28/25 at 3:54 am: R #25 was not in his room, sign out log indicated R #25 signed out of the facility on 12/26/25 at 10:20 am to go home. R #25's cellphone was called, but R #25 did not answer. R #25's wife was called, and she stated she did not pick up R #25 and R #25 was not with her at home. The Administrator (ADM) and the Director of Nursing (DON) were both notified and the police were called. 12/28/25 at 7:31 pm: R #25 returned to the facility without complaints of pain or discomfort.C. On 01/11/26 at 2:56 pm during an interview with R #25, he stated there was a miscommunication regarding his overnight pass in December 2025. R #25 stated he was only out of the facility for one night and that was approved, but the facility though he was out of the facility longer than that. R #25 also stated while he was out of the facility, the DON sent him threatening messages stating he needed to pick up his belongings from the facility because he was being discharged . R #25 confirmed he was confused and he felt threatened by those messages. R #25 also stated when he returned (on 12/28/25), his nurse went into his room and hit his foot while using foul language towards him. R #25 confirmed he felt intimidated by the nurse and the DON, and he reported this to the Assistant Director of Nursing (ADON) #2. D. On 01/15/26 at 12:05 pm during an interview with Registered Nurse (RN #5) she stated R #25 went out on approved out of facility leave (on 12/27/25), but the night shift nurse (on 12/27/25 through 12/28/25) did not know R #25 had left the facility. RN #5 also stated R #25 told her when he returned to the facility, the night shift nurse went into his room and tapped him on the feet. RN #5 stated R #25 told her that he felt like a child after the night shift nurse tapped his feet, and he did not like that treatment from her. E. On 01/15/26 at 1:28 pm during an interview with the ADON #2, he stated R #25 reported to him that the night nurse tapped R #25's foot when he returned to the facility. The ADON #2 confirmed R #25 reported to him that R #25 did not like that treatment by the night shift nurse. The ADON stated he reported R #25's concerns to the DON and Administrator, and the night shift nurse was suspended. F. On 01/15/26 at 1:54 pm during an interview with the ADON #1, she stated she was aware of R #25 stating that when he returned to the facility on [DATE], the night shift nurse used foul language with him and hit his feet. The ADON #1 confirmed this incident was being investigated, but she was not aware of the outcome. G. On 01/15/26 at 3:06 pm during an interview with the Regional Nurse Consultant (RNC), she stated there was a miscommunication between the DON and R #25 when R #25 had approved out of facility leave. The RNC stated R #25 was with his daughter and the DON tried to contact R #25. The RNC also stated due to the DONs concerns regarding R #25 missing, the night shift nurse was relieved that R #25 was back in the facility and was only lecturing R #25 while tapping R #25's foot in a friendly manner. The RNC confirmed she was not made aware of the DONs text messages to R #25 regarding discharge until the survey. The RNC stated the night shift nurse should not have tapped R #25's feet especially since R #25 interpreted that act as abusive. The RNC also confirmed the DONs text messages to R #25 were inappropriate and that was going to be investigated. H. On 01/15/26 at 3:15 pm during an interview with the Regional Administrator (RA), she stated R #25 did not report this to ADON #2 until the beginning of this survey (01/12/26). The RA stated the DON was scared that R #25 was missing when she sent (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	those text messages to him. The RA confirmed the DON did not intend to upset R #25, but R #25 did interpret those messages as a threat. The RA stated this incident is currently being investigated and the findings will be submitted to the State Agency.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR; a federal requirement to help ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) Level 1 screening was completed accurately for 1 (R#6) of 1(R #6) resident reviewed, when the PASRR level 1 indicated no mental health diagnosis despite admission documentation identifying a diagnosis of bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). This deficient practice could result in the facility failing to identify and address residents' mental health needs and ensure appropriate screening and services at admission.The findings are:A. Record review of R # 6's face sheet revealed R #6 was admitted to the facility on [DATE] with the following diagnoses:Unspecified dementia, moderate, with agitation (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment).Bipolar disorder, unspecified.B. Record review of R #6's PASRR, completed on 06/03/25, indicated R #6 did not have a diagnosis of a mental illness.C. On 01/13/26, at 2:26 pm, during an interview, the Admissions Coordinator (AC) stated Admissions reviewed PASRRs for residents upon admission. AC stated she and the admissions liaisons were responsible for ensuring the PASRR forms were accurately completed. AC acknowledged R #6's PASRR at admission indicated R #6 had no mental health diagnosis. AC acknowledged R #6 was admitted to facility with a diagnosis of bipolar disorder. AC stated it was her expectation the inaccuracy on R #6's PASRR would have been identified and corrected upon admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to revise the care plan for 1 (R #11) of 1 (R #11) resident reviewed for oxygen (O2) use. If the facility is not updating the care plan to reflect the residents' current care areas and treatment, then the facility may not be providing the appropriate care and treatment to meet the residents' needs. The findings are:A. Record review of R #11's face sheet revealed R #11 was admitted into the facility on [DATE]. B. Record review of R #11's physician orders dated 12/16/25 revealed R #11 was prescribed O2 at 2 liters per minute (LPM) via nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs). C. Record review of R #11's care plan dated 12/23/25 revealed O2 use was not care planned for R #11. D. On 01/15/26 at 9:56 am during an interview with Certified Nursing Assistant (CNA) #2, he confirmed R #11 wears O2 every day. E. On 01/15/26 at 3:09 pm during an interview with the Regional Nurse Consultant (RNC), she confirmed R #11's care plan should include O2 use, but it does not.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure pain management was provided in accordance with professional standards for 1 (R #25) of 3 (R #21, 25 and 60) when staff administered pain medication to a resident when the resident reported pain levels of 2 - 7, which did not meet the physician's ordered parameters of 8 or higher. If staff are not following physicians' orders then residents are at risk of being over medicated and may have inadequate pain control. The findings are:Based on interview and record review, the facility failed to ensure pain management was provided in accordance with professional standards for 1 (R #25) of 3 (R #25, #00 and 00) when staff administered pain medication to a resident when the resident reported pain levels of 00 - 00, which did not meet the physician's ordered parameters of 00 -00. If staff are not following physicians' orders then residents are at risk of being over medicated and may have inadequate pain control. The findings are:A. On 01/12/2026 at 3:09 pm during an interview, R #25 stated that sometimes the facility does not have his pain medication and they have to get it out of the emergency supply. He stated he regularly takes oxycontin (narcotic pain medication) for pain. B. Record review of R #25's physicians' orders revealed the following:- An order dated 12/16/25 for Oxycontin HCl Oral Tablet, 5 milligrams (mg). Give 5 mg by mouth every four hours as needed for pain. Use for severe pain, level 8 or above- An order dated 01/05/26 for Oxycontin HCl Oral Tablet, 5 milligrams (mg). Give 5 mg by mouth every four hours as needed for pain. Use for severe pain, level 8 or above. Pain level scale is as follows:* 0: No pain.* 1: Very mild pain, barely noticeable. * 2: Minor pain. * 3: Noticeable pain but manageable. * 4: Moderate pain. * 5: Moderately strong pain. * 6: Strong pain that interferes with daily activities.* 7: Severe pain, limits normal activities. * 8: Very strong pain. * 9: Intense pain, unable to converse.* 10: Worst pain possible. C. Record review of R #25's Medication Administration Records revealed the following:- 12/01/25 - 12/31/25. Oxycontin was administered on 12/16/25, 12/20/25, and 12/21/25 with the documented pain level of 5; on 12/23/25 with a documented pain level of 6; and on 12/23/25 and 12/30/25 with a documented pain level of 7. - 01/01/26 - 01/31/26. Oxycontin was administered on 01/09/26 with a documented pain level of 2, on 01/07/26 and 01/13/26 with a documented pain level of 3; on 12/05/25 (twice) 12/06/25, 12/08/25 and 12/14/25 with a documented pain level of 5; and on 12/07/25 with a documented pain level of 6. D. On 01/15/26 at 12:12 pm during an interview, RN #4 stated that she was not used the physicians' orders stating a specific pain level; she verified the orders for R #25 were specifically ordered for a pain level greater than 8. She verified the administrations in December and January were all administered with a pain level lower than 8. She stated she would consider the administrations as not following physicians' orders. E. On 01/15/2026 at 3:00 pm during an interview with the Regional Nurse Consultant (RNC) confirmed the physicians' orders had not been followed for oxycontin administration when it was administered for any pain level under 8.

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	01/15/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interviews; the facility failed to acquire medications for 1 (R #61) of 9 (R 35, R #16, R #26, R #58, R #61, R #65, R #67, R #89, and R #103) residents. This deficient practice is likely to result in missed doses of medication continuing, and potentially lead to serious harm, exacerbation of disease process, or other adverse outcomes for residents.The findings are:A. On 01/12/26 at 4:18PM, during an observation of medication administration, Registered Nurse (RN) #1 administering medications for R #61, Symbicort aerosol 160-4.5 mcg (micrograms)/act (per actuation/puff) inhaler (budesonide [a bronchodilator]/formoterol [a steroid]; inhaled medication to expand lungs and airway) not administered.B. On 01/12/26 at 4:18PM during an interview with RN #1, she stated the medication is not available and is not present in Rx Now machine (a device for storing medications) as an emergency supply. RN #1 stated she spoke with pharmacy regarding inhaler for R #61, currently awaiting delivery of medication.C. Record review of R #61 medication administration shows missed doses of the Symbicort Aerosol 160-4.5 mcg/act inhaler as follows:01/10/26 evening dose missed01/11/26 and 01/12/2026 missed doses for morning and evening01/13/2026 missed morning doseD. On 01/13/26 at 1:37 PM during interview with Director of Nursing (DON), she stated the expectation she has for staff regarding missed medications is to take as soon as possible. If multiple days are present without the medication she is to be notified. DON stated once notified she would call pharmacy and provider to have medication or alternate delivered. DON stated there is an emergency kit for one time usage, and if medication is not present there to call pharmacy immediately as there is an agreement between their supplier for local pharmacy to obtain medication if needed quickly. DON confirmed the process was not followed for R #61's missing Symbicort Aerosol 160-4.5 mcg/act inhaler and acknowledged missed doses of medication.