STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325079	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mimbres Memorial Nursing Home	900 West Ash Street Deming, NM 88031

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 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** 34303 Based on observation, record review, and interview, the facility failed to keep resident free from sexual abuse for 1 (R #1) of 2 (R #1 and R #2) residents sampled for abuse. This deficiency caused R #1 to have severe psycho-social distress having to deal with sexual abuse and past trauma brought on by the sexual abuse without mental health service. The findings are: A. Record review of R #1's medical record revealed R #1 was admitted on [DATE]. B. Record review of R #1's nursing progress notes revealed the following: 1. 02/01/24 R #1 was addmitted for therapy due to a right hip fracture with repair due to a fall. R #1 is alert and oriented, and able to make her needs known. 2. 02/01/24 R #1 is alert and oriented to herself. R #1 is able to express her needs. R #1 does require staff assistance for her ADLs. R #1 is nonweight bearing to the right lower extremity. R #1 is incontinent on both bowel and bladder. D. Record review of the facility complaint investigation file, no date, revealed the following: 1. The facility initial incident report, dated 02/18/24, revealed: a. R #1 alleged CNA #1 was helping her in the shower when CNA #1 put his fingers inside of her. b. R #1 stated the incident occurred one or two weeks ago [prior to 02/18/24]. E. Record review of R #1's nursing progress notes revealed the following: 1. On 02/18/24, a CNA reported R #1 had a complaint that needed to go to facility management. Administrator was notified and came into the facility to speak with R #1. 2. On 02/18/24, the nurse for R #1 was notified by the Administrator that R #1 reported she was sexually abused by a male CNA staff two weeks before 02/18/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2024
NAME OF PROVIDER OR SUPPLIER Mimbres Memorial Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 900 West Ash Street Deming, NM 88031	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 02/29/24, Note Text: Resident met with Interim ADON, Interim DON, Interim Administrator, Social Worker, and BOM for care conference regarding notification by the Ombudsman that the Resident feels that she would like therapy s/t (secondary to) alleged event which occurred on 02/18/2024. Resident confirmed she would like mental health and/or therapy services and was notified that appointment and transportation will be made to a local mental health clinic by SW and/or designee for the earliest available appointment. F. On 03/07/24 at 11:26 am, during an interview R #1 stated she was not sure of the day, but CNA #1 was assisting her during a shower. When CNA #1 washed her backside, his fingers went in her vaginal area. R #1 stated I did not tell him anything. I froze. What do I tell him? That never happened to me . I was in shock . It took a week to tell someone. I did not know what to say . R #1 also stated she was previously in an abusive relationship. R #1 stated it took her [AGE] years to run away from that relationship. R #1 stated the incident was hard, I have not been this depressed for years . I have not got therapy they keep changing the date (R #1's mental health appoinment was on 03/07/24 at 12:30 pm). G. On 03/07/24 at 11:26 am, during an observation, R #1 was visibly in distress. R #1 was crying, voice shaky, with periods of pause in speech when she discussed the incident with CNA #1. R #1 was also in distress when she discussed how the incident brought up the trauma from a previous relationship. H. On 03/07/24 at 12:18 pm during an interview, the Administrator stated on 02/18/24 she received a call that R #1 had a complaint for management. The Administrator stated she had gone home for the evening but came back to talk to R #1. The Administrator confirmed R #1 reported CNA #1 had sexually abused her during a shower a few weeks before, but R #1 did not know the date. The Administrator confirmed she started her investigation and reported it to the appropriate agencies immediately. The Administrator confirmed R #1 had an appointment for behavioral health services scheduled for 03/07/24 (the first appointment since the allegation of sexual abuse was made). The Administrator stated the Ombudsman brought up behavioral health services, and they held a meeting with the resident on 02/29/24. The Administrator confirmed the facility did not schedule or consider behavioral health services [prior to the Ombudsman], because the resident did not request it. The Administrator confirmed R #1 did get emotional when she discussed the sexual abuse. There were different subsequent conversations about the sexual abuse with staff during conferences and law enforcement personal for investigative purposes. The Administrator stated [after the incident] they offered to transfer R #1 to a different facility or home with home health, but the resident wanted to stay on 02/29/24.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34303 Based on record review and interview, the facility failed to have evidence that a thorough investigation of an allegation of abuse was conducted and preventive measures to keep residents safe were implemented for 1 (R #1) of 2 (R #1, and R #2) residents sampled for abuse. This deficient practice could likely result in residents being at risk of continued abuse if allegations are not thoroughly investigated and preventative measures are not implement. The findings are: A. Record review of R #1's medical record revealed R #1 was admitted on [DATE]. B. Record review of R #1's nursing progress notes revealed the following: 1. 02/01/24 R #1 was addmitted for therapy due to a right hip fracture with repair due to a fall. R #1 is alert and oriented, and able to make her needs known. 2. 02/01/24 R #1 is alert and oriented to herself. R #1 is able to express her needs. R #1 does require staff assistance for her ADLs. R #1 is nonweight bearing to the right lower extremity. R #1 is incontinent on both bowel and bladder. C. Record review of the facility complaint investigation file, no date, revealed the following: 1. The facility Initial Incident Report, dated 02/18/24, revealed: a. R #1 alleged CNA #1 was helping her in the shower when CNA #1 put his fingers inside of her. b. R #1 stated the incident occurred one or two weeks ago [prior to 02/18/24]. 2. The facility Complaint Narrative Investigation Report, no date, revealed a. R #1 stated CNA #1 was helping her in the shower and he put his hands inside of her. b. Facility actions after the incident: see attached c. Future preventative/corrective action for resident(s) health and safety: see attached d. Conclusion: see attached. 3. Attached document. It was confirmed CNA #1 was assigned to care for R #1 on 02/04/24. It was also confirmed CNA #1 was assigned to shower R #1 on 02/08/24. Human resources have been given the finding of this investigation and will make its decision on the future employment of [name of CNA #1] (nurse aide). 4. Staff did not document the facility action, future preventive/corrective action, or conclusion. 5. Two witness statements were documented from CNA #2 and Nurse #1. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Both staff memeber were working with R #1 on 02/18/24 when she reported the allegation to them. b. It was not clear if either of the two staff members were working with R #1 at the time of the allegation ocurance 1-2 week(s) prior to 02/18/24. c. Both staff witness statement only referred to the moments surrounding R #1 reporting the allegation of abuse to them, with no documentation of the events surrounding the allegation's occurance 1-2 week(s) prior. 6. Staff did not document any other witness statements of the events surrounding the allegation's occurance 1-2 week(s) prior. 7. Eight resident safe surveys were documented with three questions: a. How are you doing? b. Do you feel safe? c. Do you have any concerns with your care? d. Staff did not document any specific questions about the care they received from CNA #1 or questions related to sexual abuse. e. There was no doucmentation that CNA #1's bathing technique was questioned or evaluated. D. On 03/07/24 at 11:26 am, during an interview R #1 stated she was not sure of the day, but CNA #1 was assisting her during a shower. When CNA #1 washed her backside, his fingers went in her vaginal area. R #1 stated I did not tell him anything. I froze. What do I tell him? That never happened to me . I was in shock . It took a week to tell someone. I did not know what to say . R #1 also stated she was previously in an abusive relationship. R #1 stated it took her [AGE] years to run away from that relationship. R #1 stated the incident was hard, I have not been this depressed for years . I have not got therapy they keep changing the date. E. On 03/07/24 at 12:18 PM during an interview, the Administrator stated R #1 made an allegation of sexual abuse on 02/18/24. She started her investigation and reported it to the appropriate agencies immediately. The Administrator confirmed R #1 could not recall the date of the incident. In her investigation, the Administrator confirmed CNA #1 showered R #1 on 02/08/24. The Administrator confirmed CNA #1 was on administrative leave and has not returned to the facility. The Administrator confirmed CNA #1 was not asked specifically about R #1 during the facility investigation. The Administrator stated she unsubstantiated R #1's allegation of sexual abuse, because they could not say it did or did not happen. The Administrator also confirmed the facility had a discussion on 03/07/24 about R #1 only being showered by female staff members but this had not yet been implemented. F. On 03/07/24 at 1:20 PM during an interview, the HR Manager (HRM) confirmed HR and the Administrator interviewed CNA #1 for their investigation. The HRM confirmed she did not ask CNA #1 specifically about R #1 but only asked why someone would make an allegation like that against him. The HRM stated CNA #1 was not sure why. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. Record review of the Facility Abuse, Neglect and Exploitation Reporting & Prevention policy procedure review, dated 02/13/20, revealed the following: 1. Investigation: As soon as possible, all information related to a report of abuse, et al (and others), shall be obtained in writing from all persons with knowledge of the reported incident. Pertinent interviews are conducted in a confidential, professional manor with need to know priority of information. These interviews may include the resident, if possible, the individual reporting the event, all staff on duty at the time of the event with any probable first-hand information, and other individuals present in the area at this time of the reported incident. The interviews are put in writing, and discussed only by those responsible for determining substantiation of the report. 2. Prevent Further Abuse the Administrator or designee in his or her absence will implement corrective action based on the course/outcome of the investigation to prevent any further abuse from that could include, b. Staff changes will be made as appropriate . f. Follow up counseling for the resident(s) deemed to be in need will be initiated by social service.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34303 Based on record review and interview, the facility failed to develop a comprehensive care plan for (R #1) of 2 (R #1 and R #2) residents sampled for abuse. This deficient practice could likely result in staff being unaware of the needs of residents. The findings are: A. Record review of R #1's medical record revealed R #1 was admitted on [DATE]. B. Record review of R #1's admission MDS revealed it was completed on 02/05/24. C. Record review of R #1's care plan, dated 02/01/24, revealed the following: 1. R #1's wished to return home. 2. Preferences for activities. 3. Advanced directives for emergencies. 4. The record did not include any other care plan documentation to include diagnosis, treatment/medications, assistance needed and provided by the facility, etc. D. On 03/07/24 at 12:49 pm, during an interview the DON confirmed R #1's Care Plan was not complete. The DON stated the facility should have completed R #1's care plan to include resident specific needs of care.

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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 0740 Level of Harm - Actual harm Residents Affected - Few	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** 34303 Based on observation, record review, and interview, the facility failed to provide metal health services for 1 (R #1) of 2 (R #1 and R #2) residents sampled for abuse, when they failed to provide metal health services for R #1 after she alleged sexual abuse by a staff member providing care to her. This deficiency caused R #1 to have severe psycho-social distress having to deal with sexual abuse and past trauma brought on by the sexual abuse without mental health service. The findings are: A. Record review of R #1's medical record revealed R #1 was admitted on [DATE]. B. Record review of R #1's nursing progress notes revealed the following: 1. 02/01/24 R #1 was admitted for therapy due to a right hip fracture with repair due to a fall. R #1 is alert and oriented, and able to make her needs known. 2. 02/01/24 R #1 is alert and oriented to herself. R #1 is able to express her needs. R #1 does require staff assistance for her ADLs. R #1 is nonweight bearing to the right lower extremity. R #1 is incontinent on both bowel and bladder. D. Record review of the facility complaint investigation file, no date, revealed the following: 1. The facility initial incident report, dated 02/18/24, revealed: a. R #1 alleged CNA #1 was helping her in the shower when CNA #1 put his fingers inside of her. b. R #1 stated the incident occurred one or two weeks ago [prior to 02/18/24]. E. Record review of R #1's nursing progress notes revealed the following: 1. On 02/18/24, a CNA reported R #1 had a complaint that needed to go to facility management. Administrator was notified and came into the facility to speak with R #1. 2. On 02/18/24, the nurse for R #1 was notified by the Administrator that R #1 reported she was sexually abused by a male CNA staff two weeks before 02/18/24. 3. On 02/29/24, Note Text: Resident met with Interim ADON, Interim DON, Interim Administrator, Social Worker, and BOM for care conference regarding notification by the Ombudsman that the Resident feels that she would like therapy s/t (secondary to) alleged event which occurred on 02/18/2024. Resident confirmed she would like mental health and/or therapy services and was notified that appointment and transportation will be made to a local mental health clinic by SW and/or designee for the earliest available appointment. (continued on next page)

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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 0740 Level of Harm - Actual harm Residents Affected - Few	F. On 03/07/24 at 11:26 am, during an interview R #1 stated she was not sure of the day, but CNA #1 was assisting her during a shower. When CNA #1 washed her backside, his fingers went in her vaginal area. R #1 stated I did not tell him anything. I froze. What do I tell him? That never happened to me . I was in shock . It took a week to tell someone. I did not know what to say . R #1 also stated she was previously in an abusive relationship. R #1 stated it took her [AGE] years to run away from that relationship. R #1 stated the incident was hard, I have not been this depressed for years . I have not got therapy they keep changing the date. R #1 was unsure when her appointment was scheduled for. G. On 03/07/24 at 11:26 am, during an observation, R #1 was visibly in distress. R #1 was crying, voice shaky, with periods of pause in speech when she discussed the incident with CNA #1. R #1 was also in distress when she discussed how the incident brought up the trauma from a previous relationship. H. On 03/07/24 at 12:18 pm during an interview, the Administrator stated on 02/18/24 she received a call that R #1 had a complaint for management. The Administrator stated she had gone home for the evening but came back to talk to R #1. The Administrator confirmed R #1 reported CNA #1 had sexually abused her during a shower a few weeks before, but R #1 did not know the date. The Administrator confirmed she started her investigation and reported it to the appropriate agencies immediately. The Administrator confirmed R #1 had an appointment for behavioral health services scheduled for 03/07/24 (the first appointment since the allegation of sexual abuse was made). The Administrator stated the Ombudsman brought up behavioral health services, and they held a meeting with the resident on 02/29/24. The Administrator confirmed the facility did not schedule or consider behavioral health services [prior to the Ombudsman], because the resident did not request it. The Administrator confirmed R #1 did get emotional when she discussed the sexual abuse. There were different subsequent conversations about the sexual abuse with staff during conferences and law enforcement personal for investigative purposes. The Administrator stated [after the incident] they offered to transfer R #1 to a different facility or home with home health, but the resident wanted to stay on 02/29/24. I. Record review of the Facility Abuse, Neglect and Exploitation Reporting & Prevention policy procedure review date 02/13/20 revealed, Prevent Further Abuse the Administrator or designee in his or her absence will implement corrective action based on the course/outcome of the investigation to prevent any further abuse from that could include . f. Follow up counseling for the resident(s) deemed to be in need will be initiated by social service.