STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325214	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Rainbow Nursing Center	240 Casa Blanca Road Casa Blanca, NM 87007

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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 - 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** 35632 Based on record review and interview, the facility failed to prevent resident to resident sexual abuse for 1 (R #17) of 3 (R #5, #17 and #33) residents reviewed for abuse. This deficient practice likely resulted in psychosocial harm and distress for R #17, as evidence by the resident to become more withdrawn and isolated, experience anxiety and fear, and weight loss. The findings are: A. Record review of R #17's face sheet indicated she was admitted on [DATE] with the following diagnoses: - Cataract extraction (surgery to replace eye lens with an artificial one), - Osteoporosis (low bone mass leading to deterioration of bone tissue) with fracture, - Depressive disorder (depression; a mood disorder that causes a persistent feeling of sadness and loss of interest), - Chronic pain. B. Record review of R #17's nursing progress notes indicated the following: - Dated 08/19/24 at 8:05 pm, the Administrator in Training (AIT) notified the Director of Nursing (DON) that the night before R #17 reported to the Charge Nurse that a male resident [R #100] entered R #17's room while she was sleeping and was sexual towards her. The AIT notified Administrator, made a report to the State agency, and initiated an investigation. The DON notified R #17's Power of Attorney (POA; a person who is chosen to make decisions on your behalf when you are unable) on 8/19/24 at 7:27 am of the incident, but R #17 notified the POA yesterday, 08/18/24, that a male resident entered her room. (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 0600 Level of Harm - Actual harm Residents Affected - Few	- Dated 08/21/24 at 5:51 pm, R #17 went to the hospital on 08/19/24, and she underwent a computed tomography scan (CT scan; provides a more detailed view of tissues, blood, vessels and bones) on her abdomen. Doctors checked for bruising, screened for a urinary tract infection (UTI), and did bloodwork for possible sexually transmitted disease (STD). A tiny bit of blood was found in R #17's urine from possible tear to her vagina area [inconclusive until a sexual assault nursing exam (SANE) was completed.] Antibiotics were going to be prescribed, but they wanted to wait for the results from the SANE exam. Resident was scheduled for a SANE exam at 1:30 pm today 08/18/24. Resident came back to facility to pick up some of her clothing and belongings. She will stay with her family for the next two or three nights. The POA was provided medications for R #17. Resident and family would like R #17 to be discharged to the facility. Resident voiced she is scared to stay here. Resident's SANE exam went well, and she was released from the hospital on 8/20/24. - Dated 08/26/24 at 2:45 pm, a psychosocial assessment was conducted with R #17. The resident continued to stay in her room and spoke of leaving the facility. The Social Services Director (SSD) let R #17 know the Psychiatrist would come by today to speak with her. The resident stated she was okay with that. The Psychiatrist diagnosed R #17 with acute stress syndrome. R #17 told the Psychiatrist that she had nightmares and was afraid. R #17 stated she wanted to discharge from the facility, and the SSD discussed it further with the resident's POA. C. Record review of R #17's medical record did not include results of the SANE exam. D. Record review of R #17's therapy progress notes, dated 09/25/24, indicated the following: - The Chief Complaint Section: After recent trauma, the patient isolated in her room and sleeps more than usual. Therapy Data, Assessment and Plan Note indicated the following: 08/26/24 Patient confided in her Certified Nursing Assistant (CNA) that another resident came into her room during the night and assaulted her. Plan section: The patient will continue to receive psychotherapy services to address her emotional distress and to monitor for signs of post traumatic stress disorder (PTSD). Resident continues to be seen ongoing for therapy services. E. Record review of a statement made by Nurse #9, the statement revealed the following: Resident Report of Sexual Abuse on Sunday Night:R #17 requested a private meeting with me and CMA #1 to her room at 1900 (7:00 pm) in order to lodge a complaint about an awful encounter with a male resident last night. R #17 alleged at nighttime he entered her room and sat on other bed claiming that is just a friendly visit and only wanted to watch television which she is not comfortable with, so when she is about to sleep she asked him to leave her room which he refused. She later went to bed and five minutes later he came up to her demanding sex which he forcefully pulled her undergarments and had his way with her. She said she did not react because of fear of her life because of his ill behavior. When he left the room she walk to the nurses station and reported to night shift nurse on Sunday and to report to facility authority. She asked for him to be kept away from her in which we provided close monitoring throughout the shift. F. Record review of R #17's care plan indicated the following for psychosocial well-being : (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- Dated 08/20/24, R #17 was a victim of sexual assault by a male resident and had a diagnosis of acute stress reaction. G. Record review of R #17's hospital record indicated the following: - She was seen in the emergency roiagnom on [DATE] for acute pelvic pain and sexual assault. - Medical Decision Making Section: Present for evaluation of pelvic pain and cramping. Has a history of bladder spasm (having a sensation of needing to urinate) but have been well controlled over the last several years. R #17 denies vaginal bleeding. Abdominal exam is benign (negative) at the time of evaluation. Low suspicion of vaginal tear (an injury to the tissue around your vagina and anus.) Imaging was obtained and somewhat limited but negative for signs of traumatic injuries. H. Record review of the weights for R #17 revealed staff documented the following: - On 09/02/24, 101.8 pounds. - On 10/01/24, 100.6 pounds. - On 11/01/24, 98.6 pounds. - On 12/01/24, 92.0 pounds. I. On 12/16/24 at 3:29 pm, during an interview with R #17, she stated she wanted to go to a different facility. She stated she did not have anyone to talk to here. She stated her roommate was sort of mean, not talkative, and got mad easily. R #17 stated that one night she sat in her room and watched the evening news. She stated she went to bed when the news was over . She stated another resident came into her room and sat on the other bed. R #17 stated he would leave and come back. She stated he told her he was lonely. R #17 stated she told him it had been a long day, and she was ready to go to bed. R #17 stated he left her room, and she went to bed. R #17 stated the resident came back later while she was asleep. She stated he pulled her down to the bottom of the bed and had his way with her. R #17 stated the resident did not bother her before this incident. She stated she was too scared to get out of bed to tell someone, but she did tell someone the next day about what happened to her. R #17 expressed concern the resident might come back to the facility. J. On 12/17/24 at 3:34 pm, during an interview with the Staffing Coordinator, she stated the male resident, who allegedly went into R #17's room, was put on a one-to-one immediately after the incident was reported until he was later discharged from the facility. She stated he had a girlfriend at the facility, and he did not bother anyone else that she was aware. K. Record review of facility investigation report dated 08/23/24 identified that following facility awareness of the incident, local law enforcement was contacted to file a report, R #100 was sent out to PsychER on [DATE] and upon return from the hospital R #100 was provided 30 day discharge notice after an attempt to get an emergency discharge order from tribal court judge failed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	L. On 12/18/24 at 10:10 am, during an interview with Social Services Director (SSD), she stated she did not work at the facility at the time of the incident, but she had a lot of concerns about R #17. She stated R #17 lost some weight, she did not leave her room, and self-isolated. She stated she brought her concerns up with management and in a clinical meeting in the morning. The SSD stated she visited R #17 often. She stated R #17 saw a psychiatrist who came to the facility every couple of weeks. The SSD stated R #17's sexual abuse triggered previous issues, and that contributed to her not wanting to leave her room. The SSD stated R #18 was afraid she was going to be shamed by others. The SSD stated she spoke to the resident's daughter a lot, and they discussed interventions like moving rooms, blessing the resident's room, and having a medicine man come out. The SSD stated they would like to remove all triggers for R #17, but R #17 always states she would think about it [offered interventions]. M. On 12/19/24 at 8:44 am, during an interview with Activities Director (AD), she stated R #17 used to be more engaged than she was now. She stated R #17 used to walk up and down the halls to get some exercise, and she would take her lunch tray back to the kitchen after she was finished eating. The AD stated R #17 did not do these things anymore. The AD stated R #17 shut down. The AD stated R #17 will come out of her room with her family when they visit her. N. On 12/20/24 at 12:29 pm, during an interview with the Psychiatrist, she stated R #17 had acute post traumatic stress disorder (PTSD.) The Psychiatrist stated she went to speak with R #17 right after the abuse happened and saw her multiple times after the incident. The Psychiatrist stated R #17 was more withdrawn than she was before the incident. The Psychiatrist stated R #17 used to walk down the halls for exercise, but she did not do that anymore. She stated R #17 slept a lot more now. The Psychiatrist confirmed that she saw R #17 was on 08/26/24, 09/13/24, 09/25/24, 10/21/24, 11/22/24, 12/06/24 and 12/20/24. The Psychiatrist stated R #17 has been awake the last few times she met with her [some visits she was asleep]. She stated the facility has offered R #17 multiple different options, like changing rooms, but the resident has not accepted any of these things yet.

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F 0657 Level of Harm - Potential for minimal 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** 50752 Based on record review, the facility failed to ensure staff revised the care plan for 1 (R #15) of 1 (R #15) residents reviewed when staff failed to update care plan after falls. This deficient practice could likely result in staff being updated and implementing the needs and treatments of resident. The findings are: A. Record review of R #15's face sheet, dated 12/18/24, revealed she was admitted to the facility on [DATE] with multiple diagnoses including but not limited to: - Heart Failure. - Anxiety disorder. - Restlessness and agitation. - Unspecified dementia. B. Record review of the facility's Falls With and Without Injury Report revealed R #15 had four falls in August 2024: - On 08/09/24, fall without injury. - On 08/21/24, fall with injury. - On 08/23/24, fall with injury. - On 08/27/24, fall with injury. C. Record review of R #15's Fall Assessement revealed the following: - Dated 08/09/24, fall risk score of 24, high fall risk. - Dated 08/21/24, fall risk score of 15, high fall risk. - Staff did not complete an updated Fall Assessment for 08/23/24. - Staff did not complete an updated Fall Assessment for 08/27/24. - Dated 08/28/24, fall risk score of 19, high fall risk. D. Record review of R #15's care plan, dated 10/10/24, revealed the facility did not care plan the resident's falls until 09/26/24.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on record review and interview, the facility failed to ensure 1 (R #13) of 1 (R #13) resident reviewed for pressure ulcers (a wound caused by prolonged pressure occurring in bony areas of the body) received the necessary treatment and services to promote healing and prevent new ulcers from developing when staff failed to perform wound care for multiple days. This deficient practice likely worsened the wound for R #13, exposing bone and osteomyelitis (bone infection). The findings are: A. Record review of R #13's face sheet revealed the resident was initially admitted to the facility on [DATE] with multiple diagnoses to include: - Muscle wasting and atrophy (loss of skeletal muscle mass), - Type 2 diabetes mellitus with diabetic neuropathy (type of nerve damage that can occur with diabetes), -Chronic kidney disease, stage 4 (severe.) B. Record review of R #13's care plan, dated 08/05/24, revealed the following: - R #13 was readmitted to the facility with a Stage 2 pressure ulcer to the coccyx (tail bone located at the end of the spine.) - R #13's wounds will heal without complications. - R #13's staff will provide care per providers orders. - Send to emergency room (ER) for evaluation and treatment of wounds per provider's order. C. Record review of R #13's Physician Orders revealed an order dated 09/27/24 for wound care: Unstageable pressure ulcer to sacrum (bottom of the spine). Cleanse with wound cleanser and pat dry. Apply the wound loosely packed with an iodoform packing strip (small strip of sterile gauze), apply sure prep (hospital-grade, non-stinging barrier film) to the peri-wound (tissue surrounding a wound), and cover with bordered foam dressing. Wound Care completed daily and as needed (PRN.) D. Record review of R #13's progress notes, dated 11/09/24, revealed the Wound Care Nurse reported on 11/09/24 that the resident's wound care had not been done for two days. She stated the resident's bandages were grossly soiled, with more than 50 percent (%) dark red blood and dark, yellow-tinged drainage seeping through the wound dressing. E. Record review of the facility's Five-Day Follow-Up report, dated 11/19/24 and written by the Director of Nursing (DON), revealed Registered Nurse (RN) #12 did not complete daily wound care on 11/07/24 and 11/08/24 as ordered by the provider.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 35632 Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required dementia and abuse training for 12 (CNAs #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11 and #12) of 19 (CNAs #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, and #19) CNAs reviewed for dementia and abuse training. This deficient practice could likely result in the nurse aides not receiving the necessary training to meet the care needs of the residents. The findings are: A. Record review of the facility's most current abuse and dementia training list, dated December 2023 to December 2024, revealed 12 CNAs did not receive abuse training, dementia training, or both. B. On 12/18/24 at 10:10 am, during an interview with the Social Services Director, she stated she did not think the staff received dementia. C. On 12/19/24 at 3:30 pm, during an interview with the Interim Administrator, she stated the abuse and dementia training list, dated December 2023 to December 2024, was the most current employees who worked at the facility. She confirmed all nursing staff should complete the trainings. D. On 12/20/24 at 2:50 pm, during an interview with the Nurse Educator, she stated the dementia training on 11/26/24 was for all staff, but the staff who signed the sheet were the only ones who showed up for the training. She stated the other staff who did not come should have reviewed the training, but there was not any documentation to show they did.