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	06/26/2025

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

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an unexpected death to the State Survey Agency for 1 (R #1) of 1 (R #1) resident reviewed for clinical decline and death. The facility failed to initiate an internal investigation, submit a reportable event to the State Agency, and document clinical findings in the medical record following the resident's death. If the facility fails to report unexpected deaths, then the State Survey Agency cannot evaluate compliance with Federal regulations.The findings are: A. Record review of R #1's face sheet revealed an admission date of 08/03/24 with the following diagnoses: End-stage renal disease (kidney disease). Chronic respiratory failures with hypoxia (respiratory system is unable to adequately get oxygen into the blood). Diabetes mellitus (DM; a disease in which the body cannot make or properly use insulin). Hypertension (HTN; high blood pressure). B. On 06/25/2025 at 9:26 a.m., during an interview, the Assistant Director of Nursing (ADON) stated R #1 passed away after going to dialysis (a treatment that filters waste, toxins, and extra fluid from the blood) on 05/09/2025. C. Record review of R #1's progress notes, dated 05/09/2025 through 06/20/2025, showed the facility did not conduct an internal investigation regarding R #1's unexpected death, and the facility did not report the resident's death to the State Survey Agency. D. On 06/25/2025 at 10:46 a.m., during an interview, the Administrator stated the facility did not submit a report regarding the resident's unexpected death to the State Survey Agency, and the facility did not conduct a formal review into the resident's unexpected death. She stated they did not complete an incident report (a formal document detailing an event that occurred) or a mortality investigation (a thorough review conducted after a death to determine the cause and contributing factors), because R #1's death happened offsite. E. On 06/26/2025 at 2:26 p.m., during an interview, the Medical Director stated the facility notified her of the resident's death. She stated she expected the facility to notify the State Survey Agency for an unexpected death.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325214	A. Building B. Wing	06/26/2025

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

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate and complete documentation in the medical record for 1 (R #1) of 1 (R #1) resident reviewed for death and discharge status. The facility failed to document the resident's death in the progress notes and inaccurately listed the resident as discharged to home, rather than deceased . If the facility fails to maintain complete and accurate records, then care outcomes cannot be appropriately tracked, regulatory compliance is compromised, and opportunities for review or improvement may be missed. The findings are: A. On [DATE] at 9:26 a.m., during an interview, the Assistant Director of Nursing (ADON) stated R #1 passed away after going to dialysis (a medical treatment which filters waste and excess fluid from the blood) on [DATE].B. Record Review of R #1's progress notes, dated [DATE], showed staff did not document the resident was transported to dialysis and died after arrival at the dialysis center. C. Record review of the facility's Admit/Discharge Report, dated [DATE] through [DATE], revealed R #1 was discharged to home or self-care (routine discharge) on [DATE].D. On [DATE] at 10:12 a.m., during an interview, the Administrator reviewed the facility's admissions and discharges list in which staff documented R #1 was discharged to home instead of deceased . The Administrator stated the document was inaccurate, and the staff should have updated the discharge status.E. On [DATE] at 2:26 p.m., during an interview, the Medical Director stated she expected staff to document resident deaths in the clinical record, and the records should accurately reflect the resident's status.