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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. (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:	(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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 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.

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

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51919 Based on interviews, and record review, the facility failed to assist a resident in gaining access to vision services when staff failed to make appointments or arrange for transportation for 1 (R #30) of 1 (R #30) residents. This practice could likely lead to an increase in the risk of missing early signs of serious eye diseases like glaucoma (a group of eye conditions that can cause blindness) and macular degeneration (a medical condition which usually affects older adults and results in a loss of vision in the center of the visual field because of damage to the retina), which often have no noticeable symptoms in their early stages, potentially leading to significant vision loss or blindness if left untreated. Additionally, it could likely lead to missing a resident's prescription needs, causing eye strain and difficulties with daily activities. The findings are: A. Record review of R #30's Minimum Data Sets (MDS; a federally mandated assessment instrument completed by facility staff) revealed the following: - Admission MDS, dated [DATE], R #30 had impaired vision. - Quarterly MDS, dated [DATE], R #30 had an impaired vision. B. Record review of R #30's care plan, dated 10/4/24, revealed R #30 had age related impaired vision. The care plan listed a goal aimed to arrange Ophthalmologist (a specialist in the branch of medicine concerned with the study and treatment of disorders and diseases of the eye)/Optometrist (an eye care specialist who examine, diagnose, and treat injuries and health conditions that affect your eyes and vision) consult and to implement recommendations annually and as needed for R #30. C. On 12/16/24 at 12:10 pm, during an interview, R #30 stated she asked a staff to assist her to schedule an eye appointment earlier this year, but she did not get any response from staff. R #30 could not remember the exact date or the staff member's name. D. On 12/19/24 at 3:49 pm during an interview with Nurse #4, she stated staff scheduled R #30 for an eye appointment on 6/14/24. She stated they had to cancel that appointment, because they did not have transportation to take R #30 to her appointment. Nurse #4 stated the facility had to evacuate the building after the cancelation due to a widespread roof leak problem, and nobody rescheduled the appointment after that.

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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 51919 Based on observation and staff interview, the facility failed to ensure staff secured the medications inside the medication room and made them inaccessible to unauthorized staff and residents. This practice could likely give access to unauthorized staff, residents, and visitors, and could lead to medication misuse. The findings are: A. On 12/16/24 at 1:42 pm, during an observation, Nurse #2 put the medication room key inside a drawer at the nursing station. B. On 12/16/24 at 1:45 pm during an interview, Nurse #2 stated she kept the medication room key inside an unlockable drawer at the nurses station. She stated somebody was always available at the nurses station to guard the drawer. C. On 12/16/24 at 2:15 pm during an observation, the nursing station was unattended by nurses or staff. D. On 12/17/24 at 10:11 am during an interview, Nurse #4 stated the Certified Medication Aids (CMAs) were responsible to hold the medication room key, and sometimes they were not available when nurses needed the key. Nurse #4 stated they lost many keys when staff took them home, so she decided to keep the key in a drawer inside the nursing station. E. On 12/18/24 at 10:00 am during an interview, the facility's Interim Administrator stated she was not sure how to secure the medication room keys. She stated the medications should be locked. She stated nurses and CMAs should not keep the key in an unlocked drawer at the nursing station, but they should always keep it on their person. F. On 12/20/24 at 12:52 pm during an interview, the facility's Pharmacist stated he expected nurses and CMAs to keep the medication room secured since it contained insulin and over the counter medications. He stated nurses and CMAs should not keep the key in an unlocked drawer at the nursing station, but they should always keep it on their person.

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 51919 Based on observations, interviews, and record reviews, the facility failed to: 1. Ensure staff followed contact precautions (used for individuals with infections that can spread through direct or indirect contact with the patient or their environment) before contact with a resident and his environment for 1 (R #13) of 1(R #13) residents. This practice could likely lead to an increased risk of transmission of the bacteria to other patients and healthcare workers, potentially causing more infections due to direct contact with contaminated surfaces or the infected patient, which could result in serious complications like sepsis (presence of bacteria and infectious organisms in the blood stream) or even death if left untreated. 2. Demonstrate its measures to minimize the risk of Legionella (a type of bacteria that can cause legionellosis; a serious chest infection) and other opportunistic pathogens in the building water systems by not having a documented water management program. This failure to affect all residents in the facility. This deficient practice is likely to increase the risk of exposure to legionella bacteria and potentially outbreaks of legionellosis in the facility. The findings are: Contact Precautions A. Record review of R #13's progress notes, dated 9/27/24, revealed the resident was admitted to the facility on contact precautions due to methicillin resistant staphylococcus aureus (MRSA; bacteria that are resistant to treatment with semi-synthetic penicillin) in coccyx (tail bone located at the end of the spine) wound. B. On 12/18/24 at 10:00 am during observation and interview, Housekeeper #1 did not put on gloves or an isolation gown before she entered R #13's room to pick up trash. Further observation revealed there was a contact precautions sign on the resident's room door which instructed staff and visitors to do the following: 1. Everyone must clean their hands, including before entering and when leaving the room. 2. Providers and staff must also put on gloves and a gown before room entry and discard the gloves and the gown before room exit. C. On 12/18/24 at 10:02 am, during an interview, Housekeeper #1 stated she did not know R #13 was on contact precautions. D. On 12/18/24 at 10:05 am during observation and interview, Certified Nurse Assistant (CNA) #1 entered R #13's room, stayed a few seconds, and exited the room. CNA #1 did not put on gloves or an isolation gown before she entered R #13's room. CNA #1 stated she would only put on gloves and a gown if she had to clean the resident's infected wound. (continued on next page)

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 10/19/24 at 10:32 am during an interview with Nurse #4, she stated Resident #13 was on contact precautions. She stated she expected Housekeeper #1 and CNA #1 to put on gloves and an isolation gown before they entered R #13's room. Water Management Program F. Record review revealed that the facility did not have a documented water management program to minimize the risk of Legionella in the facility's water system. G. On 12/18/24 at 11:46 am during an interview with the Maintenance Technician, he stated the facility did not have a water testing system or any related documents. H. On 12/18/24 at 3:50 pm during an interview with the facility's Administrator, she stated they did not have a system for water testing or water services.

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

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 51919 Based on interviews and record review, the facility failed to designate one or more individuals as the Infection Preventionist (IP) who was responsible to assess, develop, implement, monitor, and manage the infection prevention and control program (IPCP; a set of practices and procedures that aim to reduce the spread of infections in healthcare facilities and other settings). This practice could likely cause a lack of dedicated oversight and implementation of proper infection control practices across the facility and lead to potential resident harm and a greater risk of outbreaks. The findings are: A. On 12/18/24 at 9:48 am, during an interview with Nurse #4/MDS Nurse, she stated the previous Director of Nursing resigned at the end of November 2024 and did not involve her (Nurse #4) in the process of infection control. She stated the Interim Administrator did not ask her to do any infection control duties, and she did not have any qualifications to perform infection prevention and control duties. B. On 12/18/24 at 10:00 am, during an interview with the facility's Interim Administrator, she stated the previous Director of Nursing handled the infection control reporting. She stated Nurse #4 and the current senior ranking nurse were not officially assigned to any infection control duties.

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

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 51919 Based on interviews and record review, the facility failed to ensure nurses educated a resident or a resident's representative on the benefits and potential side effects of the pneumococcal immunization (a shot that helps protect you from serious bacterial infections caused by pneumococcal bacteria) before nurses offered the immunization for 1 (R #7) of 1 (R #7) residents. This practice could likely lead to improper decision making by R #7's legal guardian due to inadequate discussion on the risks and benefits of the immunization. The findings are: A. Record review of R #7's physician orders, dated 11/25/24, revealed an order to administer Prevnar vaccine (pneumococcal immunization) 0.5 milliliter intramuscular (administered in the muscle.) B. Record review of R #7's face sheet dated 08/01/24, revealed R #7's son was her legal guardian and consented to her pneumococcal immunization. C. Record review of R #7's progress notes, dated 11/19/24, revealed Nurse #5 called R #7's legal guardian to obtain consent to R #7's pneumococcal immunization. The notes did not mention any education on the benefits or the potential side effects of the immunization. D. On 12/19/24 at 12:53 pm during an Interview with R #7's legal guardian, he stated a nurse called him offering to administer a pneumococcal immunization to his mother (R #7). He stated the nurse did not discuss any benefits or potential side effects of the immunization. E. On 12/19/24 at 1:20 pm during an interview, Nurse #4 stated she expected Nurse # 5 to educate R #7's legal guardian on the benefits and any potential side effects of the immunization when Nurse #5 called to obtain the consent. She stated Nurse #5 did not work at the facility any longer.

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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.