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	12/31/2025

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 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 #1) of 1 (R #1) resident reviewed when facility staff inappropriately applied physical restraint during the provision of care. If the facility performs inappropriate use of physical restraint during resident care, 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 the facility's policy titled Preventing Resident Abuse, revised December 2013, revealed the facility prohibits rough handling of residents and requires staff to manage resident behaviors in a manner that prevents injury, pain, or distress, including monitoring staff practices to identify inappropriate physical handling during resident care. B. Record review of R #1's face sheet revealed R #1 was admitted to the facility on [DATE] with the following diagnoses: Unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),Alzheimer's disease (a disease which causes irreversible changes in memory, thinking, and behavior). C. Record review of R #1's nursing progress notes dated 12/01/25 at 4:53 p.m., revealed R #1 had a skin tear to her right lower quadrant (right lower abdomen- stomach) and a large bruise to her right hand. D. Record review of R #1's Quarterly Minimum Data Set assessment (MDS; a federally mandated assessment instrument completed by facility staff) dated 12/05/25 revealed R #1's?Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) revealed a score of 02 (00 to 07 is severe impairment). E. Record review of facility's facility incident report dated 12/01/25, revealed Certified Nurse Aide (CNA) #1 and CNA #2 were attempting to take R #1 to the restroom and R #1 was swinging her arms to hit the CNAs.F. On 12/29/25 at 10:15 a.m., during an interview with CNA #1, she stated on 12/01/25, she attempted to take R #1 to the restroom and she pulled R #1's wheelchair backward several steps from the day room area toward the hallway after R #1 initially resisted going to her room, to go to the restroom. She further stated that during toileting (assistance using the toilet), R #1 became combative and attempted to strike CNA #2. She confirmed she held R #1's hands across R #1's chest, to prevent R #1 from hitting CNA #2. G. On 12/29/25 at 11:24 a.m., during an interview with CNA #2, she stated she assisted R #1 with toileting and confirmed R #1 resisted care, attempted to hit and kick staff. CNA #1 held R 31's hands during care to prevent R #1 from striking staff. She further stated approximately two to two-and-a-half hours later that day on 12/01/25, during another toileting attempt with R #1, she observed bruising to R #1's right hand and identified a skin tear to R #1's right lower quadrant of the abdomen; which she reported to nursing leadership. CNA #2 confirmed she reported her findings to the Director of Nursing (DON). H. On 12/29/25 at 1:17 p.m., during an interview with Assistant Director of Nursing (ADON), he stated he did not believe the staff intentionally attempted to harm the resident, but stated staff should have stepped away and notified nursing staff rather than continuing care during R #1's combative behavior. The ADON stated the (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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(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	facility was notified of bruising to the resident's hand later on 12/01/25 and R #1 also had a superficial (outer layer) skin tear to the right lower quadrant of the abdomen. He stated the skin tear appeared superficial and may have been related to brief (adult-sized disposable diaper designed for incontinence) change, though he could not definitively determine the cause. I. On 12/29/25 at 1:59 p.m., during an interview with the Administrator, she stated she was notified of bruising to R #1's hand following an incident involving CNA #1 and CNA #2 on 12/01/25. She stated she reviewed the available video footage, which showed staff attempting to encourage R #1 to go to the restroom for several minutes prior to entering the resident's room, during which R #1 became increasingly agitated. The administrator stated the facility does not have video monitoring inside resident rooms and therefore could not observe what occurred during toileting, but she immediately suspended CNA #1 and CNA #2 pending investigation. She stated staff reported restraining R #1's hands during care because R #1 was attempting to strike staff. The administrator confirmed it is the facility's expectation, that when a resident becomes combative, staff should step away, redirect, or notify nursing staff rather than continue hands-on care. The Administrator confirmed facility staff rough handling or applying physical restraint to residents during care is not acceptable.