STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325035	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Vida Llena	10501 Lagrima DE Oro NE Albuquerque, NM 87111

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to protect the residents from the potential for accidents and hazards for 2 (R #s 2 and 24) of 2 (R #s 2 and 24) residents reviewed for falls when the facility: Used a mechanical transfer device (a device designed to help staff move a resident from one place to another within a room or from one position to another) to transfer R #2, who did not require the use of a mechanical transfer device, which led to a fall. Failed to complete a fall risk assessment as required for R #24. Failed to follow R #24's care plan and provide a fall mat. If the facility is not using fall mats for residents' safety as care planned, completing fall risk assessments as required, and inappropriately using a mechanical transfer device, then this deficient practice could likely result in residents getting injured in avoidable accidents and putting residents at risk of serious injury and serious harm. ? The findings are: R #2: A. Record review of R #2's face sheet revealed R #2 was admitted into the facility on [DATE] with the following diagnoses: 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).B. Record review of R #2's care plan dated 12/10/24 revealed R #2 is dependent on staff for most of her activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). C. Record review of R #2's Kardex (documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) indicated R #2 was a one person stand and pivot transfer with gait belt (safety device used to assist individuals with mobility issues, providing support during transfers and helping to prevent falls). A mechanical transfer device was not documented as being necessary to assist R #2 with transfers. D. Record review of R #2's electronic medical record (EMR) revealed there was no documentation available that indicated R #2 required a Sara lift (also known as a sit-to-stand lift, is designed to assist partially mobile individuals in transitioning from a seated to a standing position) or any mechanical transfer device to assist with transfers. E. Record review of R #2's emergency room (ER) visit follow-up dated 12/15/25 revealed R #2 was discharged to the hospital after experiencing a witnessed fall in the facility after being transferred using a Sara lift. R #2 sustained a head injury and a skin tear to her left wrist. R #2 was discharged back to the facility on [DATE]. F. On 12/16/25 at 2:33 pm, during an interview with R #2's son, he stated R #2 recently fell, and the reason she fell had to do with her being transferred incorrectly by the facility nursing staff. R #2's son confirmed R #2 fell when she was being transferred from her bed to a wheelchair. G. On 12/16/25 at 1:00 pm during an interview with Certified Nursing Assistant (CNA) #8, he stated CNAs should be familiar with how each resident is transferred prior to transferring a resident. H. On 12/19/25 at 8:08 am, during an interview with the Director of Nursing (DON), she stated the fall experienced by R #2 occurred because a CNA used a Sara lift to (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfer R #2, and R #2 does not require a Sara lift. The DON stated R #2 fell while being transferred with the Sara lift, which required R #2 to go to the hospital. The DON confirmed all nursing staff should be familiar with the transferring needs and requirements of each resident prior to assisting with a resident transfer. R #24: I. Record review of R #24's face sheet revealed R #24 was admitted into the facility on [DATE] with the following diagnoses: Aphasia (disorder that results from damage (usually from a stroke or traumatic brain injury) to areas of the brain that are responsible for language),Dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life),Alzheimer's disease (a type of dementia that affects memory, thinking and behavior). J. Record review of R #24's care plan dated 08/10/25 revealed R #24 has had nine falls. R #24 had fallen out of bed and out of his wheelchair on multiple occasions, related to leaning forward in his wheelchair, confusion, balance problems, poor communication/comprehension, and R #24 is unaware of safety needs. Facility staff interventions for the falls included a fall mat on both sides of the bed, when R #24 is in bed. K. Record review of R #24's fall assessments located in R #24's electronic health record (EHR) revealed a fall assessment had not been completed as required for R #24 since September 2024. L. On 12/15/25 at 3:03 pm, during an interview with R #24's wife, she stated R #24 has had many falls. He has fallen forward out of his wheelchair and has sustained a head injury at least four times. R #24's wife stated she does not think the facility is preventing R #24's falls like they should be. M. On 12/18/25 at 2:30 pm, during an observation of R #24, he was observed lying in bed sleeping. R #24's fall mat was not below his bed as required and was stored against the wall. N. On 12/22/25 at 10:55 am during an interview with the DON, she stated residents are expected to have fall assessments completed upon admission, quarterly, and after each fall experienced by a resident. The DON confirmed R #24 did not have fall risk assessments completed as required and should have. The DON also confirmed R #24 should have a fall mat present anytime he is lying in bed, and he did not.