Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

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	09/12/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on observation and interview, the facility failed to store and serve food under sanitary conditions when staff failed to: 1. Properly store raw salmon. 2. Maintain expired dry storage items. This deficient practice is likely to affect all 50 residents listed on the resident census list, provided by the Administrator on [DATE], and could likely lead to foodborne illnesses in residents if food is not stored properly and safe food handling practices are not adhered to. The findings are: Food storage: A. On [DATE] at 10:00 am during an inspection of the kitchen, raw salmon was stored in a zip-lock bag above small cups of salsa in the refrigerator. B. On [DATE] at 10:15 am during an interview, the Director of Dining Services stated staff should not store the raw salmon above the cups of salsa, because it can contaminate the salsa. The Director of Dining Services stated all staff are responsible to check and make sure food was stored in the correct places so there was not cross-contamination. C. On [DATE] at 10:19 am during observation of the dry storage, revealed the following: - Four unopened and expired bottles of salad dressings were mixed with unexpired ones. - A bottle of liquid smoke with a broken seal and without a lid. D. On [DATE] at 10:20 am during an interview, Kitchen Staff (KS) #1 stated expired salad dressing should not be in the dry storage area. KS #1 stated staff should throw the salad dressing away when it expires. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	E. On [DATE] at 10:23 am during an interview, the Director of Dining Services stated staff should check the dry storage area every two days to ensure that expired items were not stored there. The Director of Dining Services stated unsealed items were unacceptable in the dry storage area. He stated the liquid smoke could be retained if it was adequately sealed and labeled with the date.

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48645 Based on observation, record review, and interview the facility failed to maintain proper infection prevention measures when the facility failed to ensure a resident's oxygen nasal cannula [device that gives you additional oxygen (supplemental oxygen or oxygen therapy) through your nose] did not drag on the hallway floor while the resident sat in her wheelchair and headed to an activity for 1 (R #3) of 1 (R #3) residents. Failure to ensure nasal cannulas are not dragging on the floor of the facility could likely cause the spread of infections and illness to the resident. The findings are: A. Record review of R #3's physician orders revealed an order, dated 07/11/2023, for 2 liters per minutes continuous oxygen via nasal cannula for hypoxia (low levels of oxygen in the blood stream). B. On 09/09/24 at 10:07 am during observation of the 600 hall, R #3 sat in her wheelchair in the middle of the hallway near room [ROOM NUMBER] and propelled herself toward an activity. R #3's nasal cannula and oxygen line drug behind her on the facility floor. C. On 09/09/24 at 10:08 am during an interview with R #3, she stated she did not know her oxygen drug on the floor behind her. R #3 further stated she was grossed out the oxygen cannula that she put in her nose drug on the floor that everyone walked on. D. On 09/12/24 at 9:25 am during an interview with the facility Infection Preventionist Registered Nurse, he stated the oxygen tubing and nasal cannula should never drag on the floor. He stated it was an infection control issue due to the possible contamination of the floor with bacteria, viruses, and germs.