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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to safeguard clinical record information by leaving Private Health Information (PHI) regarding residents of the 600-nursing unit, where unauthorized people had ability to access it. If the resident's clinical information is not sufficiently safe guarded, resident's PHI is likely to be viewed by unauthorized residents, visitors, and staff. The findings are: A. On 12/17/25 at 9:11 am during an observation of the unit medication cart located by the fireplace in the common room, a white piece of paper with PHI containing resident's names and resident vital signs was visible to all and left unattended. B. On 12/17/25 at 9:12 am during an interview with Licensed Practical Nurse (LPN) #2, she confirmed the unattended white piece of paper contained PHI and was left visible on the medication cart. C. On 12/17/25 at 2:39 pm during an observation, the 600-unit medication cart was left unattended outside of room [ROOM NUMBER] with PHI containing full resident names, prescribed medications, and allergies visible to the public on the computer. D. On 12/17/25 at 2:40 pm during an interview with Registered Nurse (RN) #1, he confirmed the PHI contained full resident names, prescribed medications, and allergies were visible to anyone that walked by the computer. RN #1 confirmed the best practice is to ensure resident PHI is not visible to everyone. E. On 12/18/25 at 7:55 am during an observation, the daily unit census with PHI containing full resident names and room numbers was unattended and visible to anyone that walked by the 600-unit medication cart. F. On 12/18/25 at 7:55 am during an interview with LPN #3, she confirmed the PHI of resident names and room numbers was unattended and visible to anyone that walked by the 600-unit medication cart. LPN #3 confirmed this information should always be covered to protect resident PHI. G. On 12/18/25 at 10:07 am during an interview with the Director of Nursing (DON), she stated the expectation is for PHI to be protected and not to be open for anyone's ability to view.

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
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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to protect and promote the resident's rights to dignity, self-determination, and freedom from unnecessary restrictions for 1 (R #34) of 1 (R #34) resident reviewed for restrictive devices, when: R #34, who was documented as cognitively alert and oriented, was placed on a Wanderguard (a wearable elopement-prevention tracking device) without any documentation of unsafe wandering behaviors or elopement attempts. Additionally, there was no evidence that less restrictive interventions were considered or implemented prior to applying the device.If the facility uses unnecessary restrictive measures, such as a placement of a Wanderguard on cognitively intact residents, then residents are likely to be at risk for significant psychosocial harm and restrictions. The findings are: A. Record review of the facility's Elopement and Hazardous Wandering policy, dated 07/2010, revealed the following: Elopement is a situation in which a resident with impaired cognition and/or demonstrated a lacks safety awareness or judgment successfully leaves the organization or a secured area, as defined by the organization, undetected or unsupervised by staff,All residents will be assessed for the risk of elopement through the pre-admission and/or admission process,??All elopement occurrences will be documented,Assess and identify residents at risk of elopement,During the admission process residents will be assessed for risk of elopement. B. Record review of the facility's Wandering Resident Management (Wanderguard) policy, dated 08/2010, revealed the following: Restraining a resident who is ambulatory (to move from place to place) simply to prevent wandering away in unacceptable,Residents need to feel they are being allowed their freedom, although they are under very close observation at all times,Residents will be assessed for unsafe wandering/elopement upon admission, quarterly or significant changes in condition,Resident's care plan should reflect the Wanderguard and risk of wandering,C. Record review of R #34's admission Record, dated 12/19/25, revealed an admission date of 09/20/25 with the following diagnoses: Type I Diabetes Mellitus with hyperglycemia without coma (Type 1 diabetes where the body does not make insulin, causing high blood sugar levels, but the person is awake and not in a diabetic coma),Long-term use of insulin (use of insulin regularly over a long period to control blood sugar levels),Unspecified symptoms and signs involving cognitive functions and awareness (general, non-specific problems with thinking, memory, or awareness without a clear diagnosis),Dementia, unspecified severity, without behavioral disturbances, psychotic disturbance, mood disturbance and anxiety, (dementia of unspecified severity, without behavioral disturbance, psychotic features, mood disorder, or anxiety, is a neurocognitive disorder characterized by progressive cognitive impairment affecting memory and executive functioning, with the degree of severity not specified and no associated psychiatric or behavioral symptoms),Anxiety disorder (feelings of fear or apprehension),Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). D. Record review of R #34's Care Plan, dated 09/20/25, revealed the following: Background and customary routine (a residents usual health history and the standard or routine medical practices related to their care) prior to admission to healthcare: Resided on campus in independent living with spouse,?The resident will show competency in glycogen (a substance deposited in bodily tissues as a store of carbohydrates) administration by reverse demonstration,Resident will inform nurse when she leaves healthcare (long-term care side of the facility),Resident's cognitive status is alert,Resident is an elopement risk/wander related to history of attempts to leave the facility unattended,Monitor location every 15 minutes and document wandering behavior and attempted diversional interventions in behavior log,Resident has expressed her desire to independently choose (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	engagement of choice,Resident's daily activity preference will be maintained by R #34 and her husband,Identify pattern of wandering purposefully, aimless or escapist,Resident uses a security bracelet related to poor safety awareness and forgetfulness related to Type 1 diabetes,Resident will remain free of complications related to security bracelet use, including altered mental status, isolation or withdrawal,Ensure valid consent on chart prior to initiating restraint,Resident to remain free of complications related to security bracelet use.? ?E. Record review of R #34's Speech Therapy Discharge summary, dated [DATE], revealed the following: Dates of service: 09/24/25 through 01/15/26, Discharge reason goals met:The Montreal Cognitive Assessment (MOCA; is a brief, standardized test used to evaluate a person's cognitive function, including memory, attention, language, visuospatial skills, executive functions, and orientation, and is commonly used to detect mild cognitive impairment or early dementia): R #34's test?results were a 28 out of 30 which indicated R #34 passed the assessment and did not have severe cognitive impairments. Residents' prior cognitive assistance: no supervision needed. F. Record review of R #34's Neuropsychological Evaluation (a comprehensive assessment that evaluates various mental functions, including general intellect, language use, attention, and concentration), dated 10/23/25, revealed the following:? Resident was referred for comprehensive neuropsychological evaluation regarding current cognitive and psychological functioning to provide a diagnostic clarity and assist with treatment planning,Dementia screening was negative, Medical Director (MD) at the facility agreed with the diagnosis of neuro cognitive disorder (category of mental health disorders characterized by a decline in cognitive abilities, including memory, problem-solving, and perception, often affecting daily functioning) and disagreed with the dementia diagnosis. G. Record review of R #34's PHQ-2to 9 Evaluation (tool used to screen for depression), dated 09/26/25 through 10/23/25, revealed the following:? 09/26/25: 1. Feeling down, depressed or hopelessness-symptom present: Yes. 2. Feeling down, depressed, or hopeless-symptom frequency: 2 to 6 days. Assessment was incomplete.10/23/25: 1. Feeling down, depressed or hopelessness-symptom present: Yes. 2. Feeling down, depressed, or hopeless-symptom frequency: 2 to 6 days. Assessment was incomplete. H. Record review of R #34's Medical Safety Device Assessment (used for Wanderguard placement), dated 10/28/25, revealed the assessment was incomplete.? I. Record review of R #34's admission Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 09/26/25, revealed the following: Brief Interview for Mental Status (BIMS; screening for cognitive impairment) score of 15 (indicates intact cognition),Wandering, presence and frequency: behavior not exhibited,Feeling down and depressed: Yes (2 to 3 days). ?J. Record review of R #34's complaint intake form dated 11/07/25, revealed the following: R #34 stated she was placed on a Wanderguard and not allowed to leave her unit in the facility to attend activities offered elsewhere within the facility campus. R #34 stated she does not wish to leave the campus but feels isolated in her unit, where most residents have cognitive deficits. R #34 stated seclusion has caused feelings of depression and has negatively affected her mental health. She stated she is also unable to attend worship or socialize with people on the independent living side where she resided for four years. Facility Socials Services Director (SSD) for additional information. The SSD stated the R #34 has Type 1 diabetes and fragile blood sugars, and the facility Medical Director (MD) stated she is not safe to participate in off-unit activities. R #34's Medical Power of Attorney (MPOA; legal document which allows a person to?appoint someone else to make?healthcare decisions?on their behalf if they are?unable to make decisions?themselves) agreed with the MDs decision. K. Record review of R #34's complaint intake form dated 11/13/25 revealed, R #34 stated the Wanderguard was on her ankle and was going to ask the MD to remove it. R #34 stated she would like?to have more rights to do more things she enjoys, and she feels like a chained (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	elephant in a cage. R #34 stated having a Wanderguard makes her depressed. L. Record review of R #34's facility meeting notes (with R #34, SSD, MD, MPOA, and the Administrator) dated 11/18/25 revealed the following: R #34 expressed interest in participating in on-campus activities which provide her pleasure and purpose. The MD reported multiple recent hospitalizations and concerns regarding R #34's ability to manage her Type I diabetes, despite R #34 having a BIMS score of 14 and good memory recall. The MD also noted that R #34 has been unable to consistently follow established safety protocols for leaving the unit, including checking her blood sugar, notifying the nurse, and remaining off the unit for no more than two hours. There have been instances in which R #34 left without notifying staff or signing out, which the facility considers elopement. On one occasion, R #34's blood sugar monitoring device reported critical glucose levels while R #34 was unaccounted for, requiring staff to locate her on campus. Suggestions were made for R #34 to attend activities of her choice. The MPOA stated she would refer to medical concerns as needed but declined responsibility for providing, initiating, or monitoring off-unit activities. M. Record review of R #34's complaint follow-up form dated 11/26/25, revealed the facility is working on a new safety contract so R #34 can be on campus for three hours at a time if her blood sugars are around 80 (within normal blood sugar range) before leaving the healthcare unit (long-term care). N. On 12/19/25 at 9:30 am during an interview with the Director of Nursing (DON), she stated R #34 was assessed for elopement and considered a moderate risk. The DON stated a Wanderguard was placed on R #34 after the assessment. The DON also stated there were concerns with R #34's diabetic management, including missed insulin doses and inconsistent blood sugar monitoring. The DON confirmed in order for R #34 to leave the facility, R #34 was supposed to notify staff and nursing staff were to check her blood sugar before leaving, but this did not always happen which led to R #34 experiencing a blood sugar level of 400 (abnormally high blood sugar level). O. On 12/19/25 at 12:07 pm during an interview with the MD, she stated a Wanderguard was placed on R #34 after two other less restrictive safety measures failed. The MD described periods where R #34 demonstrated clarity followed by behavioral escalation, including removal of the wander guard, attempts to elope to see her husband and dog in independent living, and aggressive behaviors. The MD stated safety concerns were more important than R #34's independence, emphasizing the need for skilled care to manage her diabetes, though these restrictions resulted in significant limitations to R #34's freedom of movement and self-determination. P. On 12/22/25 at 8:20 am during an interview with R #34's spouse, he stated R #34 is capable of independent activities?within the area but requires transportation and supervision for certain outings. He stated it was his understanding if R #34 was on the long-term care side of the campus, she could leave the main building if she told a staff member. R #34's spouse stated his wife had left to attend to her dog and upon her return, the Wanderguard was placed on her leg. Q. On 12/19/25 at 3:20 pm during an interview with Licensed Practical Nurse (LPN) #2, she stated R #34 told her that she (R #34) felt like she was losing her independence due to the Wanderguard use. LPN #2 stated R #34 usually communicated her plans when leaving the unit, and her husband typically visited and walked with her in the courtyard. LPN #2 also stated R #34 wanted a sense of freedom and when she reported leaving, LPN #2 would inquire about her blood sugar and determine if medication was needed.?LPN #2 confirmed R #34 was able to recognize when her blood sugar was dropping and managed accordingly. LPN #2 also stated R #34 had no issues communicating with nursing staff or other staff members. R. On 12/22/25 at 1:47 pm during an interview with the Social Services Director (SSD), she stated the MD was involved in R #34's Wanderguard placement due to behavioral and diabetic concerns and recommended psychiatric evaluations at a behavioral health hospital. She stated R #34 was having emotional moments, including crying, shaking, and becoming upset about (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	issues important to her, particularly related to loss of her independence and Wanderguard use. The SSD stated R #34 was upset about the placement of the Wanderguard and expressed frustration about not being allowed to leave unattended. The SSD confirmed she was unaware of any elopement attempts by R #34, and R #34 had a BIMS of 15, indicating R #34 did not have cognitive concerns. S. On 12/22/25 at 1:50 pm during an interview with the Nurse Practitioner (NP) #1, she stated R #34 experienced emotional distress with crying due to R #34's loss of independence using the Wanderguard. The NP #1 stated R #34 verbalized feelings of being a caged animal and losing her independence and control of her life due to the placement of a Wanderguard.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a significant change in condition (major decline or improvement in the patient's health status) Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) for 2 (R #24 and R #51) of 2 (R #24 and R #51) residents reviewed for hospice care. This deficient practice could likely result in the residents not receiving the appropriate care and services they need. The findings are:? R #24: A. 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),Dysphagia (difficulty with swallowing food or liquid),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),Pulmonary embolism (is a blockage of an artery in the lungs). B. Record review of R #24's physician orders dated 11/17/25 indicated an order to refer R #24 to hospice for a diagnosis of Dementia. C. Record review of R #24's nursing progress notes dated 11/18/25 revealed R #24 began receiving hospice services. D. Record review of R #24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R #24 was not receiving hospice services, even though R #24 began receiving hospice services on 11/18/25. R #51: E. Record review of R #51's face sheet revealed R #51 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),Dysphagia (difficulty with swallowing food or liquid),Dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life),Heart Disease (describes a range of conditions that affect the heart),NSTEMI Myocardial Infarction (type of heart attack in which a minor artery of the heart is completely blocked, or a major artery of the heart is partially blocked),Peripheral vascular disease (PVD is a slow and progressive narrowing or blockage of the blood vessels),Hyperlipidemia (abnormally high levels of fats (lipids) in the blood, which include cholesterol and triglycerides). F. Record review of R #51's physician orders dated 08/25/25, indicated an order to refer R #51 to hospice for a heart disease related diagnosis. G. Record review of R #51's hospice admission form dated 08/25/25 indicated R #51 began receiving hospice services. H. Record review of R #51's MDS assessments revealed a significant change in condition MDS was not completed after R #51 began receiving hospice services. I. On 12/18/25 at 2:02 pm during an interview with MDS Coordinator (MDSC), she stated a significant change in condition MDS should always be completed when a resident begins hospice services. The MDSC confirmed R #24 and R #51 did not have a significant change in condition MDS completed after they both began hospice services, and they should have. ?

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to develop an accurate comprehensive, person-centered care plan for 1 (R #27) of 1 (R #27) resident reviewed for care planning when the facility staff failed to: Accurately reflect R #27's use of an antiplatelet medication (prevent blood clots by inhibiting the aggregation of platelets, which can help reduce the risk of heart attacks and strokes). These deficient practices are likely to result in residents not having their needs met, decreased quality of life, and avoidable decline in physical and psychosocial well-being. The findings are: A. Record review of R #27's face sheet revealed R #27 was admitted into the facility on [DATE] with the following diagnoses: Coronary Artery Disease (CAD is caused by plaque buildup in the walls of the arteries that supply blood to the heart),Paroxysmal atrial fibrillation (a type of irregular heartbeat that occurs intermittently and resolves on its own or with treatment),Congestive heart failure (the heart is unable to supply enough blood to meet your body's needs),Peripheral artery/vascular disease (PVD is a slow and progressive disorder of the blood vessels causing narrowing, blockage, or spasms in a blood vessel can cause PVD). B. On 12/15/25 at 10:43 am, during an observation and interview with R #27, she was observed to have a bruise on both of her hands. R #27 stated she was on an anticoagulant and she bruises easily. C. Record review of R #27's physician orders dated 12/16/25 indicated R #27 was on Clopidogrel Bisulfate (an antiplatelet used to prevent blood clots, inhibiting platelets attaching together to prevent a heart attack or stroke). Give 75 milligrams by mouth in the morning for CAD. Medication was for an antiplatelet and not an anticoagulant. D. Record review of R #27's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 05/27/25 indicated R #27 was documented as taking an antiplatelet medication and not an anticoagulant medication. E. Record review of R #27's care plan dated 05/28/25 indicated R #27 was on anticoagulant medication therapy and was at risk from taking blood thinning medications.? F. On 12/19/25 at 8:08 am, during an interview with Director of Nursing (DON), she stated she did not see in R #27's electronic medical record that R #27 was on an anticoagulant. She confirmed R #27 was care planned for taking an anticoagulant medication, but stated R #27 should be care planned for taking an antiplatelet medication because an antiplatelet is what R #27 is prescribed and taking. The DON stated an anticoagulant thins the blood and an antiplatelet assist the flow of platelets, so they don't attach to the walls, meaning both medications are significantly different.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide quality care that meets professional standards for 2 (R #24 and #42) of 2 (R #24 and #42) residents reviewed when staff failed to: Obtain physician orders to initiate hospice care for R #24.Follow physician orders to administer the correct dose of a diabetic medication for R #42. These deficient practices are likely to result in residents not maintaining their optimal health as planned by their medical provider. The findings are: R #24: A. 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), Dysphagia (difficulty with swallowing food or liquid), 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, Pulmonary embolism (is a blockage of an artery in the lungs). B. Record review of R #24's physician orders dated 11/17/25 indicated an order to refer R #24 to hospice for a diagnosis of Dementia. C. Record review of R #24's nursing progress notes dated 11/18/25 revealed R #24 began receiving hospice services. D. Record review of R #24's quarterly Minimum Data Set (MDS a federally mandated assessment instrument completed by facility staff) dated 11/20/25, indicated R #24 was not receiving hospice services, even though R #24 began receiving hospice services on 11/18/25. E. Record review of R #24's care plan initiated on 11/11/25 indicated R #24 was admitted to hospice for a terminal prognosis and multiple comorbidities (the simultaneous presence of two or more diseases or medical conditions in a person). F. On 12/22/25 at 12:38 pm, during an interview with the Director of Nursing (DON), she stated there should be a physician order for every resident to be admitted under hospice care. The DON confirmed R #24 did not have an active order for hospice care and should have. R #42: G. Record review of R #42's Comprehensive Care Plan dated 10/21/24, revealed R #42 had a diagnosis of Type 2 Diabetes Mellitus (DM2; a disease in which the body cannot make or properly use insulin) and an intervention to increase Metformin from 500 mg to 1,000 mg daily. H. Record review of R #42's physician orders dated 12/16/25 revealed an order for Metformin (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(medication used in diabetic management that treats high blood sugar levels) 1,000 mg (milligrams). I. On 12/17/2025 at 8:37 am during an observation, Registered Nurse (RN) #1 administered 1 tablet of 500 mg of Metformin to R #42 instead of the ordered dose (1,000 mg). J. On 12/17/25 at 8:39 am during an interview with RN #1, he confirmed he did not follow physician's orders when administering R #42's Metformin and should have. K. On 12/18/25 at 10:07 am during an interview with the Director of Nursing (DON), she confirmed the facility nursing staff should follow physician orders and administer the correct dose of medications to residents.

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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 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 (continued on next page)

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	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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to maintain acceptable parameters of nutritional status for 1 (R #3) of 1 (R #3) resident reviewed for nutrition and weight management when: The facility failed to weigh R #3 monthly as ordered by a physician. This deficient practice is likely to lead to the resident suffering from unplanned weight loss and malnutrition which could exacerbate (make worse) other medical conditions or diseases. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE] with the diagnosis of Multiple sclerosis (MS; a chronic progressive disease involving damage to the nerve cells in the brain and spinal cord, which may cause numbness, impairment of speech and muscular coordination, blurred vision and severe fatigue).B. Record review of R #3's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 12/08/25 revealed there was not a documented weight (base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice) for R #3.?C. Record review of R #3's physicians' orders revealed the following: 11/14/24: Order for regular texture diet, thin consistency.?02/04/25: Order to weigh R #3 every month for routine monitoring.08/26/25: Order for Prostat (nutritional supplement) in the morning for wound healing; 30 milliliters (ml) by mouth twice daily.? D. Record review of R #3's weight tracking located in the electronic health record (EHR) dated 03/01/25 through 12/22/25 revealed the following:?? 03/25/25 125.4 lbs (pounds), 04/01/25 125.4 lbs,07/01/25 120.8 lbs,?There have been zero documented weights since 07/01/25. E. Record review of R #3's care plan dated 08/26/25 revealed R #3 has a potential nutrition risk due to inadequate oral intakes, non-significant weight loss, and increased nutrition needs related to wound care management. Facility interventions include following the diet as ordered, encouraging meal intakes, and weighing per physician orders. F. Record review of R #3's nutritional evaluation dated 10/25/25 revealed R #3 experienced a 3% (percent) weight loss (minus 4.6 lbs, comparison weight on 04/01/25). G. On 12/22/2025 at 10:49 am during an interview with the Director of Nursing (DON), she confirmed R #3's last documented weight in the EHR was in July 2025. The DON stated R #3 should be weighed per physician orders, and if R #3 refuses monthly weights, then that should be documented in the EHR. The DON stated R #3's weights were not being consistently monitored and should have been.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to prevent a significant medication error for 1(R #34) of 1(R #34) resident reviewed for medication errors when: The facility did not administer R #34's medications accurately as ordered. If the facility fails to review and reconcile insulin orders, discontinue prior orders, verify correct dosing parameters, and prevent duplicate orders, then residents are likely to receive incorrect insulin administration and have uncontrolled blood glucose levels, which could potentially lead to serious harm. The findings are: A. Record review of the facility's Medication Administration Assistance Policy, dated 04/2017, revealed the following: Check the medication order. Ensure proper route, dose time, strength frequency and type,A licensed nurse is to notify the resident's physician immediately of problems with medications. B. Record review of R #34's face sheet revealed R #34 was admitted into the facility on [DATE] with the following diagnoses: Type I Diabetes Mellitus with hyperglycemia without coma (Type 1 diabetes where the body does not make insulin, causing high blood sugar levels, but the person is awake and not in a diabetic coma),Long-term use of insulin (use of insulin regularly over a long period to control blood sugar levels),Unspecified symptoms and signs involving cognitive functions and awareness (general, non-specific problems with thinking, memory, or awareness without a clear diagnosis). C. Record review of R #34's physician orders dated 10/02/25 through 10/03/25 revealed the following:10/02/25: Insulin Glargine-yfgn (long-acting insulin used to manage blood sugar levels). Inject 15 units at bedtime for diabetes,10/03/25: Insulin Glargine-yfgn. Inject 15 units at bedtime for diabetes. D. Record review of R #34's Medication Error Incident Report dated 10/04/25 revealed the following: Wrong dose of insulin was provided to R #34. The order was to administer 15 units of long-lasting insulin, but 17 units were given,The incorrect order was not found until 10/07/25 by the physician,R #34 had low blood sugars for multiple days after the additional administration,Order was discontinued and re-written by the physician,Wrong insulin dose was administered to R #34, resulting that required immediate interventions,R #34's niece notified on 10/07/25 at 1:00 pm. E. Record review of R #34's Medication Administration Record (MAR) dated October 2025 revealed the following: 10/02/25: Insulin Glargine-yfgn (long-acting insulin used to manage blood sugar levels). Inject 15 units at bedtime for diabetes. Order was discontinued on 10/07/25. 10/03/25: Insulin Glargine-yfgn. Inject 15 units at bedtime for diabetes. Order was discontinued on 10/07/25. F. On 12/22/25 at 1:07 PM during an interview with the Director of Nursing (DON), she stated a medication error had occurred for R #34. The DON stated R #34 received a duplicate order of insulin for several days and should not have. The DON also stated it is her expectation for all residents to receive the correct medication and dosages, per physician orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and interviews, the facility failed to ensure staff properly stored and secured medications for all residents residing on the 600 unit when: Medication carts were not secured and left unattended during medication pass. Medications were not stored appropriately with loose medications in the medication cart. Expired medical equipment was stored in the unit medication storage room. If the facility fails to secure medication carts, properly store medications, or remove expired medical equipment, then residents are likely to experience unauthorized access to medications and the use of expired drugs, potentially resulting in injury or illness. The findings are: A. On 12/17/25 at 8:18 am, during an observation of the 600 unit, a medication cart was left unlocked and unattended outside of Room (RM) #608. B. On 12/17/2025 at 8:19 am during an interview with Registered Nurse (RN) #1, he confirmed that he left the medication cart unlocked and unattended. RN #1 stated the medication carts should not be left unlocked and unattended. C. On 12/17/25 at 12:48 pm during an observation of the medication storage room, revealed the following: Universal Viral Transport for the viruses Chlamydia (common bacterial sexually transmitted infection), Mycoplasmas (bacteria known for lacking a cell wall, making them tiny and resistant to many common antibiotics), and Ureaplasma's (tiny bacteria commonly live in human genital and urinary tracks, can overgrow or be transmitted sexually, related to mycoplasmas) testing swabs were expired and dated 05/14/25 located in drawer #2. D. On 12/17/2025 at 12:48 pm during an interview with RN #1, he confirmed the date of 05/14/25 on the testing swab, and confirmed the swab was expired. RN #1 stated all expired medical supplies, and equipment should be discarded appropriately per policy. E. On 12/17/25 at 12:48 pm, during an observation of the 600-unit medication cart, an oval light blue pill (stamped with SG) was found loose in drawer #2. F. On 12/17/2025 at 12:49 pm during an interview with RN #1, he confirmed and visualized the loose pill located in drawer #2. RN #1 stated the medication carts should be free of loose medications. G. On 12/17/25 at 9:29 am during an observation of the common area, a medication cart was unlocked and unattended. Further observation revealed the medication cart contained residents?scheduled medications?(oral tablets/capsules),?eyedrops, inhalers, and?injectable medications. H. On 12/17/25 at 9:31am during an interview with Licensed Practical Nurse (LPN #2), she stated the unlocked and unattended medication cart was her responsibility. She stated it was her expectation to lock the medication cart when it was unattended. LPN #2 stated if a resident had ingested medication not prescribed to them, the resident could have had a bad drug interaction, resulting in the resident becoming sick. I. On 12/18/2025 at 10:07 am during an interview with the Director of Nursing (DON), she stated medication carts should be always locked when nurses are away from the medication cart. The DON further (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated it is also an expectation for nurses to keep medication carts clean and free from loose medications, and there should not be expired supplies in the medication rooms or carts.

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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. Based on observation and interview, the facility failed to store and serve food under sanitary conditions when staff failed to ensure: Expired foods were stored in the main kitchen and the serving kitchen. This deficient practice is likely to affect all 46?residents listed on the resident census list provided by the Administrator on 12/15/25 and is likely lead to foodborne illnesses in residents if food is not being stored properly and safe food handling practices are not adhered to. The findings are: A. On 12/15/25 at 9:07 am during the initial tour of the main kitchen revealed the following: Smal Refrigerator (Fridge): Two pink drinks in covered cups were marked use by 12/13/25.?Large Fridge: One container of salsa had a use by 12/07/25 date.?One container of boiled eggs had a use by 12/13/26 date. One individual package of cheese slices had a use by 12/13/25 date.? B. On 12/18/25 at 1:52 pm during a follow-up observation of the main kitchen revealed the large fridge had one box of fresh spinach that had a use by date of 12/03/25.C. On 12/18/25 at 2:12 pm during an observation of the small serving kitchen, revealed the refrigerator had one container of salsa that had a use by date of 12/07/25. One medium sized container of plain yogurt expired was expired on 12/17/25.?D. On 12/18/25 at 2:22 pm during an interview with the Dietary Manager (DM), he verified the expired foods and stated the expectation is the kitchen staff, including himself, be more diligent in monitoring the use by date on all foods and disposing of expired food items. He stated residents are at risk of food borne illnesses, should they receive expired food items.?

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to maintain a safe, sanitary environment to prevent transmission of infectious agents and communicable diseases for 1 (R # 39) of 1 (R # 39) resident reviewed for infection control, when: The facility failed to clean and sanitize vital sign equipment (medical tools used to measure and monitor a patient's essential physiological functions; Blood Pressure Monitors and Cuffs), after use on a resident that was placed on enhanced barrier precautions (use of gowns and gloves during high-contact resident care activities). This deficient practice is likely to result in the transmission of infections agents between residents and staff.The findings are: A. On 12/18/25 at 8:24 AM, during an observation of R #39, Licensed Practical Nurse (LPN) #3 failed to sanitize blood pressure cuffs used for R #39, who is on Enhanced Barrier Precautions. LPN #3 proceeded to document the administration of medication on a facility assigned computer on top of the medication cart. B. On 12/18/25 at 8:25 AM, during an interview with LPN #3, she confirmed she forgot to clean the blood pressure cuffs after use on R #39. LPN #3 stated blood pressure cuffs should have been cleaned prior to leaving resident's room per policy. LPN #3 also confirmed R 39 is on Enhanced Based Precautions.