

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER LA Vida Buena Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2301 Collins Drive Las Vegas, NM 87701	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>39509</p> <p>Based on record review and interview, the facility failed to ensure 1 (R #1) of 3 (R #1, #2 and #3) residents reviewed for pressure ulcers (a wound caused by prolonged pressure occurring in boney area of the body) received the necessary treatment and services to promote healing and prevent new ulcers from developing, when staff failed to conduct consistent pressure ulcer wound assessments with measurements. If the facility is not consistently assessing and measuring wounds, then resident's wounds are likely to worsen without appropriate intervention. The findings are:</p> <p>A. Record review of R #1's face sheet, dated 08/02/24, revealed she was admitted to facility on 08/08/19 with multiple diagnoses including:</p> <ul style="list-style-type: none"> - Contractures (a shortening of muscles around joints causing joint stiffness and immobility) multiple sites. - Dementia (a chronic progressive disease that leads to memory loss and decline in mental ability.) <p>B. Record review of R #1's daily care notes revealed the following:</p> <ul style="list-style-type: none"> - Dated 05/15/24, R #1 had a new pressure sore on her coccyx (lower back and upper buttocks). It was described as healing. - Dated 05/19/24, R #1's coccyx pressure sore was tunneled (the wound has grown underneath the skin) with a strong, foul odor. Blood and wound drainage on dressing. - Dated 05/28/24, an order for Bactrim (an antibiotic medication to treat infection) was received for R #1's coccyx pressure sore and an appointment was made with the wound clinic (a medical clinic that specializes in the care and treatment of wounds of all type). - Dated 06/11/24, R #1 was transported to an appointment at a wound clinic and was admitted to hospital. - Staff provided treatment to the coccyx pressure sore on a daily basis. <p>C. Record review of R #1's weekly wound progress notes revealed the following:</p> <ul style="list-style-type: none"> - The record did not contain a wound report for the week of 05/15/24. <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The record did not contain a wound report for the week of 05/22/24.</p> <p>- Dated 05/29/24, wound measured 6.0 centimeters (cm) by 4.0 cm by 4.9 cm. Had red granulation (bright red tissue that forms in a wound), slough (dead tissue within a wound) and eschar (dark, crusty tissue that forms on top of a wound) with foul odor. The note did not mention or measure any tunneling as described in daily care note on 05/19/24.</p> <p>- Dated 06/03/24, wound measured 6.0 cm by 4.2 cm by 4.5 cm. Had 10% necrotic (dead tissue), 30% slough, and 60% red granulation tissue. Tunneling was noted but not measured.</p> <p>- The record did not contain a wound report after 06/03/24.</p> <p>D. On 08/02/24 at 2:37 pm during interview with Director of Nursing (DON), she stated residents with any kind of wound would be reported to the wound care nurse, who reviewed, assessed, and measured each resident wound on a weekly basis. The DON stated the wound care nurse prepared a weekly wound report. The DON reviewed R #1's medical record and stated R #1 first had a pressure wound to the coccyx on 05/15/24. The DON stated there was not a weekly wound report until 05/29/24. She stated the next wound report was on 06/03/24. The DON stated the staff did not complete any other wound reports after this date. The DON stated the wound care nurse should have completed weekly wound reports each week.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39509</p> <p>Based on observation and interview, the facility failed to store and serve food under sanitary conditions when staff failed to:</p> <ol style="list-style-type: none"> 1. Properly label and store food items. 2. Maintain the facility kitchen free of dirt and grime. <p>This deficient practice is likely to affect all 83 residents listed on the resident census list, provided by the Administrator on 08/02/24, and could likely lead to foodborne illnesses in residents if food is not being stored properly, safe food handling practices are not adhered to. The findings are:</p> <ol style="list-style-type: none"> 1. Food storage <p>A. On 08/02/24 at 10:15 am, observation of the facility kitchen area revealed the following:</p> <ul style="list-style-type: none"> - Two, five pound bags of frozen chicken patties (2 ounces) sat outside of the freezer. They were open to air, not labeled, and not dated. - One, ten pound box of beef patties sat outside of the freezer. They were open to air, not labeled, and not dated. - One, six quart plastic container of apple sauce stored in a refrigerator and was not labeled or dated. - One, six quart plastic container of sliced cheese stored in a refrigerator and was not labeled or dated. - One package of corn tortillas were open, stored in a dry storage room, not labeled or dated. <p>B. On 08/02/24 at 10:20 am during interview, the Dietary Manager (DM) confirmed the items listed were unlabeled and undated, but staff should have labeled and dated the items. The DM stated staff should not leave potentially hazardous food (PHF; foods that must be kept at a particular temperature to minimize the growth of food poisoning bacteria or to stop the formation of toxins) open to the air and sitting on the counter.</p> <p>Free of dirt and grim</p> <p>C. On 08/02/24 at 10:15 am, observation of the facility kitchen area revealed the area under the sink and around the drain was dirty with particles of dirt and grime.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>D. On 08/02/24 at 10:20 am during interview with DM, she confirmed the area below the sink was dirty, and staff should be clean the area on a daily basis. She was unable to give a date staff last cleaned the area under the sink.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39509</p> <p>Based on observation and interview, the facility failed to maintain proper infection prevention measures when the facility experienced an outbreak of coronavirus disease (COVID; a contagious viral disease) and staff failed to:</p> <ol style="list-style-type: none"> 1. Properly dispose of used personal protective equipment (PPE; protective masks, gloves and gowns used and disposed of when staff is exposed to a contagious disease). 2. Exchange and dispose of protective mask after contact with each contagious resident. <p>These deficiencies are likely to affect all 83 residents of the facility as listed on the census provided on 08/02/24.</p> <p>The findings are:</p> <p>A. On 08/02/24 at 10:20 am during entrance to the facility through the main front doors, a sign indicated the facility had an outbreak of COVID, and all persons who entered were required to wear a protective mask.</p> <p>B. On 08/02/24 at 10:30 am during observation of the facility's halls, all staff wore protective masks as they walked about the unit and interacted with residents.</p> <p>Disposal of PPE</p> <p>C. On 08/02/24 at 1:18 pm during an interview, Certified Nurses Aide (CNA) #1 stated the facility had a recent outbreak of COVID. She stated there were many residents who were COVID positive, and they all required staff to use PPE when entering their rooms. She stated there were still several residents who were on isolation due to COVID. CNA #1 stated staff threw used PPE into trash cans lined with clear plastic trash bags. She stated she would enter the rooms as needed, take the PPE filled trash bags, tie off the top, and take the bags to the regular trash container, outside the building.</p> <p>D. On 08/02/24 at 1:30 pm during interview with CNA #2, she stated the facility had a recent outbreak of COVID. She stated there were many residents who were COVID positive, and staff were required to use PPE when entering their rooms. CNA #2 stated she would enter isolated resident's rooms as needed, take the PPE filled trash bags, tie off the top, and take the bag to the regular trash container, outside the building.</p> <p>E. On 08/02/24 at 2:10 pm during interview with the facility Infection Control Nurse (ICN), he stated the facility had a recent outbreak of COVID. He stated a total of 15 residents tested positive for COVID, and they were all placed on COVID precautions. He stated staff should have treated the used PPE as biohazardous waste, and they should have placed the PPE into red bags marked as biohazardous. He stated staff should have disposed of the red bags of used PPE in the biohazard trash cans located in a special closet within the building.</p> <p>Protective Mask</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>F. On 08/02/24 at 1:18 pm during interview with CNA #1, she stated she used the same mask throughout the day. She stated she did not dispose of her used mask before entering a COVID isolation resident room. She stated she used the same mask throughout her working day.</p> <p>G. On 08/02/24 at 2:10 pm during interview with the ICN, he stated staff should have exchanged their PPE masks before and after entering any COVID positive resident room. He stated this was not possible, because the facility did not have an adequate supply of PPE masks.</p>