

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 10/31/2024
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>39509</p> <p>Based on record review and interview, the facility failed to conduct a through investigation and failed to report timely to the State Survey Agency for 1 (R #1) of 3 (R #1, 2, 3) residents reviewed for incidents/accidents. This deficient practice is likely to prevent the state agency from properly monitoring and investigating a facility and prevent such incidents in the facility.</p> <p>The findings are:</p> <p>A. Record review of R #1's daily care note dated 08/24/24, revealed the resident was being assisted to bed by Certified Nurses Aide (CNA) #1 when he fell to the ground. CNA #1 asked that Licensed Practical Nurse (LPN) #1 to come to the room and assist with R #1. When LPN #1 arrived in the room, LPN #1 noted R #1 was on the floor with a large cut above his left eye. R #1 laid in a puddle of blood on the floor. LPN #1 reported that while assisting R #1, he stated you did this, you hit me. R #1 was cleaned and transported to hospital for further evaluation and assistance.</p> <p>B. Record review of New Mexico Health Care Authority facility report #77137, the facility reported an incident dated 08/24/24 which stated that R #1 had fallen. He was sent to the emergency room and treated for a laceration (cut) above his eye. The report also stated police arrived at the facility to investigate an allegation of abuse made by R #1 while at the emergency room . The initial report further stated that CNA #1 was accused of intentionally striking R #1.</p> <p>C. Record review of New Mexico Health Care Authority facility follow up report #77137, dated 09/05/24 revealed the follow up report did not contain any information regarding any allegations of abuse and no information regarding the outcome of an abuse investigation.</p> <p>D. On 10/31/24 at 1:50 pm during interview with Assistant Director of Nursing (ADON), he stated he had been assigned to complete the report for the final investigation of report #77137. He stated he understood the investigation related to an allegation of abuse in which CNA #1 was accused of striking R #1. ADON reviewed the follow up report #77137 dated 09/05/24 and stated the report did not contain any information regarding any allegations of abuse, any information regarding an investigation of abuse and any information regarding the outcome of the abuse investigation.</p> <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
---	-------	-----------

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 10/31/2024
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>E. On 10/31/24 at 2:30 pm during interview with the Director of Nursing (DON) and Administrator (ADM). Both reviewed the follow up report #77137 dated 09/05/24. Both confirmed the report should have contained information and summary of the facility findings regarding abuse allegations made by R #1. Both confirmed that the facility had interviewed multiple staff, taken statements from staff and concluded that R #1 had fallen, had a significant injury which was caused by CNA #1 not using proper technique to assist R #1. Both confirmed that CNA #1 should have had a second person to assist her and she should have used a Hoyer Lift (a hoist like device used to safely lift and move a person) when moving R #1. Both confirmed the follow up report was inaccurate and incomplete.</p>

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 10/31/2024
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>39509</p> <p>Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for safe transfer when staff did not have two staff present while providing care of a resident. This deficient practice likely resulted in the resident experiencing an injury, pain, discomfort and less than optimal care.</p> <p>A. Record review of R #1's face sheet, dated 11/31/24, revealed R #1 was admitted to facility on 12/04/21 with the following diagnoses:</p> <ul style="list-style-type: none"> - Unspecified lack of coordination. - Need for assistance with personal care (requires assistance when dressing, transferring positions, meal setup, showers). - History of traumatic brain injury (a sudden and significant injury of the brain). - Dementia (a chronic progressive disease of the brain that causes decline a decline of the memory). <p>B. Record review of R #1's care plan revealed the following:</p> <ul style="list-style-type: none"> - Initiated on 03/19/24, R #1 continued to be at risk for falls because of his inability to transfer safely. - Initiated on 12/17/21 and revised on 05/20/24, R #1 was at risk for falls, because of inability to transfer safely. R #1 was unaware of his safety needs. - Initiated on 06/01/23 and revised on 07/01/24, R #1 required TWO STAFF WHEN CARING FOR RESIDENT AT ALL TIMES!!!!!! R #1 had cognitive impairment due to head injury and required guidance and cueing throughout the day. <p>C. Record review of R #1's Daily Care Note, dated 08/24/24, revealed a notation by Licensed Practical Nurse (LPN) #1 of a fall in which R #1 was found on the floor of his room. LPN #1 reported R #1 bled from his head and lay in a puddle of blood. R #1 was assessed and noted to have a large hematoma [an area that is swollen and bleeding] with a laceration [a cut of the skin] to his left eyebrow.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>D. Record review of the facility's investigation documents, dated 08/24/24, for R #1's fall incident revealed a written statement by Certified Nurse Assistant (CNA) #1. She stated she answered R #1's call light, and R #1 told CNA #1 that he needed to be changed (had a soiled brief and needed a change). CNA #1 assisted R #1 to bed, changed him, and then told R #1 that she needed help from another staff to transfer him back to his chair. CNA #1 stated she told R #1 that she was going to get someone to help her transfer him back to his chair. R #1 did not want to sleep in his bed, because he usually slept in his chair. R #1 did not want to wait. He wanted to be transferred right away. CNA #1 stated she did not want to drop the resident that was why she wanted help. R #1 became angry and did not like that CNA #1 wanted to get assistance. R #1 started punching CNA #1 in the arm and told her that he was going to throw himself out of the bed. CNA #1 made sure R #1's bed was in the lowest position and then walked out of the room to let the nurse know what was going on. CNA #1 heard a noise from R #1's room, and she discovered R #1 was on the floor. There were not any other staff present in the room at the time of the incident.</p> <p>E. On 10/31/24 at 12:20 pm during an interview by phone, LPN #2 stated she witnessed CNA #1 enter R #1's room alone. LPN #2 stated she heard R #1 yell at CNA #1 to return him to his wheelchair. LPN #2 stated CNA #1 exited R #1's room, came to the nurse's station, and reported to her (LPN #2) that R #1 scratched her arm. LPN #2 stated CNA #1 returned to R #1's room alone, entered the room, and then exited. CNA #1 returned to the nurse's station and reported to LPN #2 that R #1 fell and was on the floor bleeding. LPN #2 stated she was aware R #1 was a maximal assist transfer (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort). LPN #2 advised CNA #1 to fill out an incident report.</p> <p>F. On 10/31/24 at 2:00 pm during interview with Administrator (ADM) and Director of Nursing (DON), they stated they were made aware that R #1 had fallen from his bed. They stated R #1 sustained an injury to his head and required transfer to the hospital. They stated the resident was evaluated and required several sutures (use of sterile string to sew together a wound or cut). They stated they determined that CNA #1 had failed to use proper procedures to transfer R #1. They stated R #1 required a Hoyer lift and two staff to assist him whenever he was transferred from one position to another. They stated CNA #1 failed to use a Hoyer lift or to ask for help from another staff person when she transferred R #1 from his wheelchair to his bed and from his bed back to his wheelchair.</p>		