STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325065	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Vida Buena Healthcare	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)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to promote resident choices for 1 (R #3) of 2 (R #'s 2 and 3) residents reviewed for choices when staff failed to offer R #3 showers per her preference. If the facility does not honor residents' choices, then residents are likely to experience a loss of independence and self-worth leading to feelings of frustration and depression. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE]. B. Record review of R #3's care plan dated 01/28/25, revealed R #3 required Activities of Daily Living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance with baths/showers due to physical and cognitive impairments. C. Record review of the facility's shower schedule revealed R #3's bath/shower days were scheduled for Monday, Wednesday, and Saturday each week. D. Record review of R #3's documentation survey report (ADL tracking form located in the electronic health record- EHR) dated 03/01/25 through 03/31/25 revealed R #3 was offered three (3) baths/showers out of thirteen (13) opportunities. E. Record review of R #3's shower sheets dated 03/01/25 through 03/31/25 revealed R #3 was offered four (4) baths/showers out of thirteen (13) opportunities. F. Record review of R #3's documentation survey report dated 04/01/25 through 04/08/25 revealed R #3 was offered zero (0) baths/showers out of three (3) opportunities. G. Record review of R #3's shower sheets dated 04/01/25 through 04/08/25 revealed R #3 was offered one (1) bath/shower out of three (3) opportunities. H. On 04/07/25 at 3:09 pm, during an interview, the Ombudsman (State Agency Resident Advocate) stated that R #3 told her that she was not receiving enough baths/showers while in the facility. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. On 04/07/25 at 4:57 pm, during an interview with R #3, she stated that the facility switched her from showers to baths and she will often only be offered/given one bath a week. R #3 also stated that she wants more than one bath a week and when she doesn't get that many baths a week, she feels dirty. J. On 04/08/25 at 1:56 pm, during an interview, Licensed Practical Nurse (LPN) #2 stated that she knew R #3 complained about not getting enough baths/showers in the past and she would always try to check on R #3 . LPN #2 confirmed Certified Nursing Assistants (CNAs) documented resident baths/showers on shower sheets and in the residents EHR. K. On 04/08/25 at 2:55 pm, during an interview, Nursing Aide (NA) #1 stated that R #3 will be itchy a lot and so NA #1 will try to offer her a bed bath as often as she can. NA #1 confirmed R #3 complained to her that R #3 was not being offered or given enough baths a week and NA #1 reported R #3's complaint to the nursing staff. L. On 04/08/25 at 3:05 pm, during an interview, LPN #3 stated that R #3 should be offered at least three baths/showers a week unless she requests to have more. M. On 04/08/25 at 5:08 pm, during an interview, the Director of Nursing (DON) confirmed R #3 was not offered enough baths a week and stated that R #3 should be offered/given more baths a week.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to notify the facility providers (Nurse Practitioner, Physician) when there was a change of condition for 1 (R #1) of 1 (R #1) residents reviewed. This deficient practice is likely to result in a delay in treatment or inadequate treatment. The findings are: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses: 1. Encounter for surgical aftercare following surgery on the digestive system. 2. Peritoneal Abscess (a collection of pus or infected fluid located in the inner wall of the abdomen). 3. Malignant Carcinoid Tumor (rare type of tumor that grows slowly). 4. Colostomy (Connects the colon to the stoma at the abdominal wall. Bypasses or surgically removes part of the large intestine). - R #1 was discharged to the emergency room (ER) on 01/21/25. B. Record review of R #1's nursing progress notes dated 01/21/25 at 6:30 pm, revealed facility nursing staff received report that R #1 was transferred from the local hospital to a hospital located in another city and with higher level of care capabilities. No documentation was present that stated why R #1 was being sent to the local hospital or by who. C. Record review of R #1's ER (out of city hospital) notes dated 01/21/25 at 12:27 pm, revealed R #1 was admitted to the ER with hypotension (low blood pressure) and an altered mental status related to severe Sepsis (a life-threatening condition that happens when the body's immune system has an extreme response to an infection, causing organ dysfunction) due to recent abdominal surgery. R #1 was sent to the ER for Sepsis symptoms and an abdominal drain check. D. Record review of R #1's Electronic Health Record (EHR), revealed the record did not contain any documentation that the facility provider was contacted prior to R #1 being sent to the ER. E. On 04/07/25 at 4:29 pm, during an interview, R #1's sister stated she saw R #1 on 01/18/25 in the facility and R #1 was not very responsive and R #1 looked sick. R #1's sister stated the facility staff were aware of R #1's physical presentation on 01/18/25 because she informed nursing staff of how R #1 looked. R #1's sister also stated that R #1 was sent to an out of town hospital where R #1 was diagnosed with Sepsis. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 04/08/25 at 12:55 pm, during an interview, Registered Nurse (RN) #1 stated she remembered being told by facility staff that R #1 was sent to the local ER for an unknown reason. RN #1 also stated that on the day (01/21/25), when R #1 was sent to the local ER the facility nursing staff should have notified a provider R #1 was sent to the ER. G. On 04/08/25 at 2:04 pm, during an interview, Licensed Practical Nurse (LPN) #1 stated that a provider should be notified prior to sending a resident to the ER, and if staff cannot speak to a provider prior, then the provider should be notified immediately after sending a resident to the ER. H. On 04/08/25 at 5:03 pm, during an interview, the Director of Nursing (DON) stated a facility provider should have been notified of R #1 being sent to the local ER immediately. The DON confirmed a provider was not contacted when R #1 was sent to the local ER according to R #1's EHR, and should have been. I. On 04/08/25 at 5:33 pm, during an interview, the Nurse Practitioner (NP) #1 stated the expectation is facility nursing staff will notify the provider prior to sending a resident to the ER, but if they cannot, then they should notify a facility provider immediately after sending a resident to the ER. NP #1 confirmed she was not notified that R #1 was sent to the localER on [DATE], and she should have been notified.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure medical records were updated and accurate for 1 (R #1) of 1 (R #1) resident reviewed, when the facility: 1. Failed to document a change in condition (CIC; sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains) that required R #1 to go to the emergency room (ER). 2. Failed to document the reason R #1 was sent to the ER, including documentation that indicated a facility provider was notified of R #1 being sent to theER on [DATE]. This deficient practice is likely to result in residents having an inaccurate medical record, which could result in the residents receiving less than optimal care and treatment. The findings are: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses: 1. Encounter for surgical aftercare following surgery on the digestive system. 2. Peritoneal Abscess (a collection of pus or infected fluid located in the inner wall of the abdomen). 3. Malignant Carcinoid Tumor (rare type of tumor that grows slowly). 4. Colostomy (Connects the colon to the stoma at the abdominal wall. Bypasses or surgically removes part of the large intestine). -R #1 was discharged to theER on [DATE]. B. Record review of R #1's nursing progress notes dated 01/21/25 at 6:30 pm revealed facility nursing staff received a report that R #1 was transferred from the local hospital to a hospital located in another city and with higher level of care capabilities. C. Record review of R #1's ER (out of city hospital) notes dated 01/21/25 revealed R #1 was admitted to the ER with hypotension (low blood pressure) and an altered mental status related to severe Sepsis (a life-threatening condition that happens when the body's immune system has an extreme response to an infection, causing organ dysfunction) due to recent abdominal surgery. D. Record review of R #1's Electronic Health Record (EHR) reviewed revealed the following: 1. The record did not contain any documentation for the change in condition nor the reason R #1 was to the ER. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The record did not contain any documentation that the facility's provider was contacted regarding R #1 being sent to the ER. E. On 04/08/25 at 12:57 pm during an interview with Registered Nurse (RN) #1, she stated that facility nursing staff should document a change in condition when a resident is sent to the ER, including documentation that states when a provider was notified. F. On 04/08/25 at 1:48 pm during an interview with RN #2, he stated that if a resident experiences a change in condition the facility nursing staff are required to document the change in condition, document when a provider is notified, and document any reasons why a resident is sent to the ER. G. On 04/08/25 at 5:05 pm during an interview with the Director of Nursing (DON), she stated that the facility nurses are expected to document a resident change in condition, document when a provider is notified, and document any reasons why a resident is sent to the ER. The DON confirmed R #1's change in condition, the reason he was sent to the ER, and when/if a provider was notified was not documented and should have been.