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	07/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a resident was treated with respect and dignity for 1 (R #5) of 3 (R #1, 2 and 5) residents reviewed for dignity by:1. Not allowing the resident to leave the facility per his preference.2. Re-directing the resident back to the facility when he has wanted to leave to go for a walk or shopping and not offering the resident an alternate solution/plan. This deficient practice created frustration and confusion for the resident because he did not understand why he was unable to leave. The findings are:A. Record review of R #5's face sheet revealed R #5 was admitted into the facility on [DATE].B. On 07/22/25 at 10:51 AM- during a phone interview with R #5's Sister she stated He complains about not being able to leave whenever he wants. I was told that he needs someone to sign him out. I don't know what their policy is about him leaving on his own is but he capable of making his own decisions.C. On 07/22/25 at 11:17 AM during an interview with R #5, he stated. There are no outings here at this facility. I can only go outside to the yard/ would like to walk outside the facility. I walked to the store and bought myself tennis shoes and then came back. No one told me anything. But they say I can't leave without someone signing me out now.D. On 07/22/25 at 12:37 PM during an interview with the Director of Nursing (DON), she stated, the facility van has been down for a couple of months it has affected the activity outings, Activity Department is not able to take the residents on facility planned outings. It was reported. He did leave, he went to [name of local store] and bought shoes. If we let him go out on pass it's not safe/ he has a seizures/fall. We want to make sure he is safe. He doesn't want staff going with him. He has not been deemed incompetent. We should be able to offer that someone goes with him. Even after educating him about signing himself out, he didn't sign out when he attempted to go to [name of local store]. He was not allowed to go; he was re-directed and brought back into the facility. DON confirmed R #5 can make his needs known and has a BIMS score of 15 (Brief interview for mental status 00-15 15 being the highest)E. On 07/22/25 at 1:15 PM during an interview with the Activities Assistant (AA) she stated. He (name of R #5) attends activities when he wants. He is alert and oriented. He asks when we are going to the store, we need to watch him because he will take off. He doesn't buy anything but will go for the ride. He doesn't have money sometimes. I do take him on walks when I can, but not lately. He will go out to the front, but we have to watch him because he'll take off. He thinks he's ok but he's not, he can have a seizure at any time. He cannot sign out and go alone to the store. I will stop him and call for help if I see him walking out the door.

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
	325065	A. Building B. Wing	07/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on record review and interview, the facility failed to notify the facility providers (Nurse Practitioner, Physician, and the facility Wound Care Nurse) and Guardian for 3 (R #'s 4, 9, 15) of 3 (R #'s 4, 9, 15) residents reviewed when:Guardian for R # 4 was not notified of a fall with injury above R #4's right eye on 05/28/25. The facility Registered Nurse Treatment Nurse (Wound Care Nurse) was not notified of R #9's scalp laceration (a tear or ragged cut in skin or flesh) with staples for 24 days after R #9 received scalp staples. Facility providers were not notified of R #15's worsening (becoming worse) pressure ulcer (skin wound) as soon as the wound was identified to be declining, so wound care treatment could be changed. This deficient practice is likely to result in a delay in treatment or inadequate treatment. The findings are: R #4: A. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE]. B. Record review of R #4's nursing progress notes dated 05/28/25 to 05/29/25 revealed a fall with injury above her right eye that required steri strips (breathable and waterproof bandage strips used to close or tape up wounds). C. On 07/22/25 at 12:25 pm during an interview with R #4’s guardian she stated that she was not made aware of R #4's fall on 05/28/25, and she would have expected the nursing facility staff to notify her. D. On 07/22/25 at 11:45 pm during an interview with Licensed Practical Nurse (LPN) 2, she stated she remembered one incident in May of this year that the guardian for R #4 was not called after a fall. She further stated that R #4’s guardian let her know when she made a follow up call about R #4’s fall that she was not informed about the fall in the first place. E. On 07/23/25 at 12:37 pm during an interview with the Director of Nursing (DON), she stated the nursing facility staff should have notified R #4’s guardian and they did not. R #9: F. Record review of R #9's face sheet revealed R #9 was admitted into the facility on [DATE]. G. Record review of R #9's emergency room (ER) Discharge Instructions (Orders) dated 06/13/25 revealed R #9 was to have his staples that were located on his head, to close a laceration (a tear or ragged cut in skin or flesh), removed in 7 to 10 days. H. Record review of R #9's nursing progress notes dated 06/13/25 to 06/29/25 revealed the following: 06/13/25 at 12:12 pm: R #9 returned to the facility from the ER where he had staples put into his into his scalp after falling in the facility and sustaining injuries. R #9 returned with orders from the ER doctors to have his staples removed within 7 to 10 days. On call providers were contacted (by nurse writing progress note) and awaiting orders for staple removal. (continued on next page)

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	07/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/16/25 at 4:56 am: Laceration to R #9's right side of head, laceration was sutured (a stitch or row of stitches holding together the edges of a wound or surgical incision) in the ER. 06/25/25 at 7:04 am: Pending physician orders to remove R #9's stitches. 06/29/25 at 9:00 am: Remove staples from right sides of R #9's scalp. Physician notified of purulent (thick, milky discharge that comes out of a wound meaning infection) drainage and laceration infection. 06/29/25 at 1:07 pm: Nurse removed 4 staples from R #9's scalp as ordered. After staples were removed, R #9's scalp was warm to touch and purulent indicating infection. I. Record review of R #9's physician orders dated 06/29/25 revealed, remove staples from the right side of R #9's scalp one time only. J. On 07/23/25 at 4:09 pm during an interview with the Registered Nurse Treatment Nurse (RNTN), she stated that she was not made aware of R #9's scalp staples until 07/07/25, and she would have expected the facility nursing staff to notify her of R #9's scalp staples as soon as he returned to the facility on [DATE]. K. On 07/24/25 at 9:35 am during an interview with the Nurse Practitioner (NP), she stated the facility nursing staff should have notified the RNTN of R #9's scalp staples as soon as he returned to the facility on [DATE]. The NP also stated that she would expect the RNTN to also ask about R #9's scalp staples. The NP confirmed she expects nursing staff to notify the RNTN as soon as possible and stated, Communication is basic for everything and very important. L. On 07/24/25 at 11:46 am during an interview with the Director of Nursing (DON), she stated the facility nursing staff should have notified the RNTN of R #9's scalp staples as soon as he returned to the facility on [DATE]. R #15: M. Record review of R #15’s face sheet revealed R #15 was admitted into the facility on [DATE] with a Pressure Ulcer of the Sacral Region (area at the bottom of the spine), Stage 4 (deep wounds that may impact muscle, tendons, ligaments, and bone). N. Record review of R #15’s physician orders dated 04/29/25 revealed, wound to coccyx (tailbone area; base of spine): cleanse with normal saline, cover wound bed with collagen hydrogel (wound care product to create moist environment for healing), pack with normal saline wet gauze, cover with dry dressing. One time a day for wound care. Physician order discontinued on 05/14/25. O. Record review of R #15’s physician orders dated 05/15/25 revealed, wound to coccyx- cleanse with wound cleanser or normal saline, apply calcium alginate with silver (specialized wound dressing to prevent infection) to wound bed, cover with silicone dressing, and monitor for any signs or symptoms of infection every day shift for wound care. Physicians order was discontinued on 06/20/25. (continued on next page)

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	07/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P. Record review of R #15’s physician orders dated 06/20/25 revealed, wound to coccyx- cleanse with wound cleanser or normal saline, apply calcium alginate with silver to wound bed, cover with silicone dressing, and monitor for any signs or symptoms of infection every day shift for wound care. Q. Record review of R #15’s weekly wound progress form (form completed by facility Registered Nurse (RN) Treatment Nurse- Wound Care Nurse) dated 05/28/25 through 07/07/25 revealed the following: 05/28/25: R #15’s coccyx (tailbone area; base of spine) pressure ulcer identified on 04/28/25, was measured to have a length of 5.0 cm (centimeters), width of 5.0 cm, and a depth of 3.3 cm. Notes stated, “Wound has gotten larger.” 06/03/25: R #15’s coccyx pressure ulcer was measured to have a length of 5.0 cm, width of 5.0 cm, and a depth of 3.0 cm. Notes stated, “Wound is healing well.” 06/20/25: R #15’s coccyx pressure ulcer was measured to have a length of 5.0 cm, width of 4.8 cm, and a depth of 2.9 cm. Notes stated, “Wound is healing well.” 06/24/25: R #15’s coccyx pressure ulcer was measured to have a length of 6.0 cm, width of 5.0 cm, and a depth of 2.5 cm. Notes stated, “Wound is healing slowly.” 07/07/25: R #15’s coccyx pressure ulcer was measured to have a length of 6.0 cm, width of 6.0 cm, a depth of 2.0 cm, and 3.0 cm tunneling of the wound. Notes stated, “Necrotic tissue, Wound is healing well. Orders for wounds to be seen by wound clinic sent in.” R #15’s left gluteal fold (horizontal skin crease that forms below the buttocks) pressure ulcer identified on 06/28/25, was measured to have a length of 5.0 cm, width of 6.0 cm, and a depth of 0.1 cm. Notes stated, “Orders for wounds to be seen by wound clinic sent in.” No weekly wound progress form was completed between 06/03/25 through 06/20/25, and 06/24/25 through 07/07/25. R. Record review of R #15’s weekly skin checks completed by facility nursing staff dated 06/06/25 through 07/03/25 revealed the following: 06/06/25: R #15’s coccyx pressure ulcer was not documented. 06/12/25: R #15’s coccyx pressure ulcer- wound treatment in place and wound care nurse continues to follow. 06/19/25: R #15’s coccyx pressure ulcer- wound treatment in place and wound care nurse continues to follow. 06/25/25: R #15’s coccyx pressure ulcer- wound treatment in place and wound care nurse continues to follow. 07/03/25: R #15’s coccyx pressure ulcer- wound treatment in place and wound care nurse continues to follow, shearing left buttocks. (continued on next page)

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	07/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/11/25: R #15’s coccyx pressure ulcer- wound treatment in place and wound care nurse continues to follow. Left buttock (gluteal fold) wound nurse continues to follow. 07/17/25: R #15’s coccyx pressure ulcer- wound treatment in place and wound care nurse continues to follow. Left buttock (gluteal fold) wound nurse continues to follow. S. Record review of the facility wound report dated 07/23/25 revealed the following for R #15: R #15’s coccyx pressure ulcer was measured to have a length of 6.2 cm, width of 6.1 cm, and a depth of 2.0 cm. R #15’s left gluteal fold pressure ulcer was measured to have a length of 5.20 cm, width of 5.80 cm, and a depth of 0.10 cm. T. Record review of R #15's physician orders dated 07/03/25 revealed, stage 2 wound to left gluteal fold- cleanse with normal saline, pat dry, apply collagen flakes, apply silicone dressing one time a day for wound care. U. Record review of R #15's physician orders dated 07/07/25 revealed, refer to wound clinic STAT (immediately or without delay) for a stage 2 wound to left gluteal fold and pressure ulcer of sacral region (coccyx) stage 4. V. Record review of R #15's physician orders dated 07/21/25 revealed R #15's wound clinic appointment was scheduled for 07/29/25. W. On 07/23/25 at 4:10 pm during an interview with the RNTN, she stated that she did not let the NP know about R #15's worsening coccyx pressure ulcer and left gluteal pressure ulcer until 07/07/25. X. On 07/24/25 at 9:43 am during an interview with the Nurse Practitioner (NP), she stated that she was not informed of R #15's coccyx and left gluteal fold pressure ulcers until 07/07/25. The NP also stated that if she was notified sooner of R #15's worsening coccyx pressure ulcer and left gluteal pressure ulcer, then she would have put in different wound care orders sooner. The NP confirmed she should have been made aware of R #15's worsening coccyx pressure ulcer and left gluteal pressure ulcer sooner. Y. On 07/24/25 at 3:33 pm during an interview with the Medical Director (MD), he stated that his expectation is if a resident's wounds are worsening, like R #15's coccyx pressure ulcer, then he would expect the facility providers to be notified immediately.

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	07/24/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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	07/24/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and interview, the facility failed to make prompt (done without delay; immediate) efforts to resolve resident's grievances for 4 (R #'s 13, 14, 16, and 17) of 4 (R #'s 13, 14, 16, and 17) residents reviewed by:Not responding to grievances that involved allegations of abuse and neglect for several days after the grievance was reported. Failing to educate all nursing staff, including the nursing staff involved, for grievances with allegations of abuse and neglect. If the facility is not ensuring that grievances are responded to in a prompt manner and without delay, then residents are likely at risk of continued/repeat concerns and feeling as though their concerns are unimportant to the facility.The findings are: R #13: A. Record review of R #13's reported facility grievance dated 07/17/25 revealed the following:R #13 stated that Nursing Assistant (NA) #1 answered her call light but stated that she needed to go get more bed sheets and never returned to help R #13. R #13 pressed her call light again, and an unnamed Certified Nursing Assistant (CNA) came in to assist R #13. NA #1 returned to R #13's room and was laughing while the CNA was assisting R #13. Later that day, R #13 was in the shower, and NA #1 came into the shower room and started laughing again. R #13 pressed her call light again later after the shower and NA #1 arrived at her room and told R #13 that she would return to help her, but NA #1 did not return. Facility Response: Facility Nursing staff will be provided education regarding the importance of ensuring all residents are treated with dignity and respect at all times, and education relevant to customer service. Education will be completed by July 25, 2025. Facility nursing staff will try to schedule employee named by the resident on a different hall, when possible, to minimize the care the employee provides to the resident. B. Record review of facility in-service training dated July 2025 revealed the following: Training Topics: Dementia, Residents Rights, Customer Service, and Assist All Residents in a Timely Manner with a Better Attitude.NA #1 was not documented as being present for in-service training. No documentation was available that indicated NA #1 received any in-service/training related to R #13's grievance. C. On 07/23/25 at 10:25 am during an interview with R #13, she stated that she felt humiliated when NA #1 was laughing at her in the shower. R #13 also stated that NA #1 also got mad at R #13's roommate (R #14) for using the call light.R #14: D. Record review of R #14's reported facility grievance dated 07/17/25 revealed the following:Subject: R #14 reported that NA #1 answered her call light. R #14 forgot what she needed because the nursing staff took too long to answer the call light, and NA #1 told R #14 that she should not use the call light if she could not remember what she needed. Facility Response: Facility Nursing staff will be provided with education regarding the importance of ensuring all residents are treated with dignity and respect at all times, and education relevant to customer service. Education will be completed by July 25, 2025. Facility nursing staff will try to schedule employee named by the resident on a different hall, when possible, to minimize the care the employee provides to the resident. E. Record review of facility in-service training dated July 2025 revealed the following: Training Topics: Dementia, Residents Rights, Customer Service, and Assist All Residents in a Timely Manner with a Better Attitude.NA #1 was not documented as being present for in-service training. No documentation was available that indicated NA #1 received any in-service/training related to R #14's grievance. R #16: F. Record review of R #16's reported facility grievance dated 07/16/25 revealed the following:Subject: R #16 does not want CNA #3 working with her because she does not like the way CNA #3 talks to her and treats her. Facility Response: Facility Nursing staff will be provided education regarding the importance of ensuring all residents are treated with dignity and respect at all times, and education relevant to customer service. Education will be completed by July 25, 2025. Facility nursing staff will try to schedule employee named by the resident on a different hall, when possible, to minimize the care the employee provides to the resident. G. Record review of facility in-service training dated July 2025 revealed the following: Training Topics: Dementia, Residents Rights, Customer Service, and Assist All Residents in a Timely Manner with a Better Attitude.CNA #3 was not documented as being present for in-service training. No documentation was available that indicated CNA #3 received any in-service/training related to R #16's grievance.R #17: H. Record review of R #17's reported facility grievance dated 07/18/25 revealed the following:Subject: R #17 got back from dialysis and did not get changed until 12:00 pm. CNA #4 kept passing by R #17 and did not answer R #17's call light. Facility Response: Facility Nursing staff will be provided education regarding the importance of ensuring all residents are treated with dignity and respect at all times, and education relevant to customer service. Education will be completed by July 25, 2025.I. Record review of facility in-service training dated July 2025 revealed the following: Training Topics: Dementia, Residents Rights, Customer Service, and Assist All Residents in a

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	07/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report an investigation regarding allegations abuse and neglect within the required timeframe (2 hours) for 3 (R #'s 13, 14, and 17) of 4 (R #'s 13, 14, 16, and 17) residents reviewed for grievances.If the facility is not submitting the summary of the facility's investigation to the State Agency, then the State Agency is unable to appropriately triage (review) the allegation for further investigation.The findings are: A. Refer to F0610 for related findings. R #13: B. Record review R #13's neglect incident report provided by the facility dated 07/17/25 revealed the following:Details of Incident: During an audit of facility grievances, this incident is being reported that R #13 stated Nursing Assistant (NA) #1 came to change R #13 but left to get supplies and never returned to change R #13. Another staff member came to assist R #13. After Incident Actions: NA #1 was re-educated. Details of Interventions: Investigation is ongoing. Follow-up was reported to the SA on 07/22/25 at 10:34 am. No indication that the neglect incident was reported to the SA within two hours as required. C. On 07/31/25 at 2:16 pm during an interview with the Administrator (ADM), he stated the facility did not identify an allegation of neglect for R #13's grievance dated 07/17/25. The facility identified an allegation of neglect for R #13's grievance dated 07/17/25 several days after the incident occurred during a grievance audit, indicating R #13's neglect grievance dated 07/17/25 was not reported to the SA within two hours as required. The ADM confirmed R #13's neglect incident/grievance should have been submitted to the SA sooner. R #14:D. Record review R #14's incident report provided by the facility dated 07/17/25 revealed the following:Details of Incident: During an audit of facility grievances, this incident is being reported that R #14 stated NA #1 answered the call light, but R #14 forgot what she wanted. NA #1 asked R #14 why she used the call light if she could not remember what she needed. After Incident Actions: NA #1 was re-educated. Details of Interventions: Investigation is ongoing. Follow-up was reported to the SA on 07/22/25 at 10:51 am. No indication that R #14's incident/grievance incident was reported to the SA within two hours as required. E. On 07/31/25 at 2:17 pm during an interview with the ADM, he confirmed R #14's incident/grievance should have been submitted to the SA sooner. R #17: F. Record review of the facility Abuse and Neglect Incident Reports, reviewed on 07/24/25 revealed no abuse and neglect incident report was present for R #17's incident that occurred on 07/18/25. G. On 07/31/25 at 2:18 pm during an interview with the ADM, he confirmed R #17's grievance/incident dated 07/18/25 was not submitted to the SA and should have been because this incident involved allegations of neglect.

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	07/24/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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	07/24/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and interview, the facility failed to complete a thorough investigation and report the investigation findings within five working days, for allegations of abuse and neglect for 3 (R #'s 13, 14, and 17) of 4 (R #'s 13, 14, 16, and 17) residents reviewed for grievances. If the facility is not completing an accurate and thorough investigation and submitting the summary of the facility's investigation to the State Agency, then the State Agency (SA) is unable to appropriately triage (review) the allegation for further investigation.The findings are: R #13: A. Record review of R #13's facility grievance dated 07/17/25 revealed the following:Subject: R #13 stated that Nursing Assistant (NA) #1 answered her call light but stated that she needed to go get more bed sheets and never returned to help R #13. R #13 pressed her call light again, and an unnamed Certified Nursing Assistant (CNA) came in to assist R #13. NA #1 returned to R #13's room and was laughing while the CNA was assisting R #13. Later that day, R #13 was in the shower, and NA #1 came into the shower room and started laughing again. R #13 pressed her call light again later after the shower and NA #1 arrived at her room and told R #13 that she would return to help her, but NA #1 did not return. Facility Response: Facility Nursing staff will be provided with education regarding the importance of ensuring all residents are treated with dignity and respect at all times, and education relevant to customer service. Education will be completed by July 25, 2025. Facility nursing staff will try to schedule employee named by the resident on a different hall, when possible, to minimize the care the employee provides to the resident. B. Record review of facility in-service training dated July 2025 revealed the following: Training Topics: Dementia, Residents Rights, Customer Service, and Assist All Residents in a Timely Manner with a Better Attitude.NA #1 was not documented as being present for in-service training. C. On 07/23/25 at 10:25 am during an interview with R #13, she stated that she felt humiliated when NA #1 was laughing at her in the shower. R #13 also stated that NA #1 also got mad at R #13's roommate (R #14) for using the call light.D. Record review R #13's neglect incident report dated 07/17/25 revealed the following:Details of Incident: During an audit of facility grievances, this incident is being reported that R #13 stated Nursing Assistant (NA) #1 came to change R #13 but left to get supplies and never returned to change R #13. Another staff member came to assist R #13. After Incident Actions: NA #1 was re-educated. Details of Interventions: Investigation is ongoing. Follow-up was reported to the SA on 07/22/25 at 10:34 am. A thorough investigation was not provided for R #13's 07/17/25 incident. E. On 07/31/25 at 2:16 pm during an interview with the Administrator (ADM), he stated R #13's grievance was not identified as an allegation of abuse until the facility completed a grievance audit during the survey. The ADM also stated that while he was out of the facility, he would have expected the facility staff to conduct a thorough abuse investigation, and one was not conducted. R #14: F. Record review of R #14's facility grievance dated 07/17/25 revealed the following:Subject: R #14 reported that NA #1 answered her call light. R #14 forgot what she needed because the nursing staff took too long to answer the call light, and NA #1 asked R #14 why she used the call light if she could not remember what she needed. Facility Response: Facility Nursing staff will be provided education regarding the importance of ensuring all residents are treated with dignity and respect at all times, and education relevant to customer service. Education will be completed by July 25, 2025. Facility nursing staff will try to schedule employee named by the resident on a different hall, when possible, to minimize the care the employee provides to the resident. G. Record review of facility in-service training dated July 2025 revealed the following: Training Topics: Dementia, Residents Rights, Customer Service, and Assist All Residents in a Timely Manner with a Better Attitude.NA #1 was not documented as being present for in-service training. H. Record review R #14's incident report dated 07/17/25 revealed the following:Details of Incident: During an audit of facility grievances, this incident is being reported that R #14 stated NA #1 answered the call light, but R #14 forgot what she wanted. NA #1 asked R #14 why she used the call light if she could not remember what she needed. After Incident Actions: NA #1 was re-educated. Details of Interventions: Investigation is ongoing. Follow-up was reported to the SA on 07/22/25 at 10:51 am. A thorough investigation was not provided for R #14's 07/17/25 incident.I. On 07/31/25 at 2:17 pm during an interview with the ADM, he stated that during the facility grievance audit, it was determined that R #14's grievance was a form of intimidation and should be considered an allegation of abuse. The ADM confirmed a thorough abuse investigation was not completed for R #14's 07/17/25 grievance and should have been. R #17: J. Record review of R #17's facility grievance dated 07/18/25 revealed the following:Subject: R #17 got back from dialysis and did not get changed until 12:00 pm. CNA #4 kept passing by R #17 and did not answer R #17's call light. Facility Response: Facility

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	07/24/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure staff revised the care plan for 1 (R #5) of 3 (R #1, 2 and 5) residents reviewed when staff failed to update the care plan to include R #5 not being able to leave the facility independently. This deficient practice is likely to result in residents' preferences and needs not being addressed if care plans are not updated. The findings are: A. On 07/22/25 at 11:17 am during an interview with R #5 he stated that he would like to be integrated back into the community. He further stated that the facility doesn't have any outings scheduled and he would like to go outside to walk but he was told he was not to leave the facility without someone accompanying him. R #5 feels frustrated because he is not able to exercise his rights to be able to leave the facility to go to the store or to walk around the facility grounds. B. Record review of Activity assessment dated [DATE] revealed: Page 2 question 7. Go outside for fresh air when the weather is nice: 1) Very Important C. Record review of R #5's care plan dated 06/21/25 revealed [name of R #5] stated that he went to the store to buy new pair of shoes and returned to the nursing facility. Interventions: encourage resident to let staff know when he wants to go out to purchase items. D. On 07/23/25 at 12:37 pm during an interview with the Director of Nursing (DON) she stated that R #5 was not safe to go out on his own because he had some medical issues that prevented him from being safe and making sound decisions. R #5 is not in agreement that he needs staff to participate with him when he wants to walk to the store or go for a walk. He has not been deemed incompetent. DON further stated that the facility should be able to offer someone to accompany R #5, but the option is not always offered. DON confirmed that R#5's care plan does not state that resident should not be allowed to leave the facility on his own and needs supervision at all times when he leaves the facility.

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	07/24/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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	07/24/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 #'s 9 and 11) of 2 (R #'s 9 and 11) residents when the facility failed to:Remove R #9's scalp staples within 7 to 10 days as ordered by a physician. Provide physician orders for anticoagulant (blood thinner) complications (bruising, bleeding, pain, swelling, and dizziness) monitoring (daily nursing assessments) for R #11. If the facility is not following physician orders or providing medication monitoring orders, then residents are at risk of adverse outcomes and inadequate monitoring of treatment. The findings are:R #9: A. Record review of R #9's face sheet revealed R #9 was admitted into the facility on [DATE]. B. Record review of R #9's emergency room (ER) Discharge Instructions (Orders) dated 06/13/25 revealed R #9 was to have his staples that were located on his head, to close a laceration (a tear or ragged cut in skin or flesh), removed in 7 to 10 days. C. Record review of R #9's nursing progress notes dated 06/13/25 to 06/29/25 revealed the following:06/13/25: R #9 returned to the facility from the ER where he had staples put into his after falling in the facility and sustaining injuries. R #9 returned with orders from the ER doctors to have his staples removed within 7 to 10 days. On call providers were contacted and awaiting orders for staple removal. 06/16/25: Laceration to R #9's right side of head, laceration was sutured (a stitch or row of stitches holding together the edges of a wound or surgical incision) in the ER. 06/25/25: Pending physician orders to remove R #9's stitches. 06/29/25 at 9:00 am: Remove staples from right sides of R #9's scalp. Physician notified of purulent (thick, milky discharge that comes out of a wound meaning infection) drainage and laceration infection. 06/29/25 at 1:07 pm: Nurse removed 4 staples from R #9's scalp as ordered. After the staples were removed, R #9's scalp was warm to touch and purulent indicating infection. D. Record review of R #9's physician orders dated 06/29/25 revealed, remove staples from the right side of R #9's scalp one time only. E. On 07/21/25 at 4:39 pm during an interview with R #9's daughter, she stated that the facility staff did not know when to take R #9's staples out of his head. R #9's daughter also stated that both her and her brother asked about the removal of R #9's staples on his head, but none of the nursing staff could ever tell them when the staples were to be removed, which resulted in R #9's staples remaining in his head for 16 days. F. On 07/22/25 at 3:08 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated that the facility was trying to get physician orders to remove R #9's head staples from facility providers, but they did not receive an order within the 7 to 10 days. The LPN #1 also stated that she believed R #9's staples were in his head for too long and when she removed the staples, R #9's scalp laceration was infected. G. On 07/23/25 at 11:15 am during an interview with Registered Nurse (RN) #2, she stated R #9's staples were supposed to be removed within 7 to 10 days from 06/13/25 per hospital orders, but the staples were not removed until 16 days after R #9 returned to the facility. H. On 07/24/25 at 9:34 am during an interview with the Nurse Practitioner (NP), she stated that she was made aware of R #9's infected scalp laceration on 06/29/25, but she was surprised because she thought R #9's staples were already removed. I. On 07/24/25 at 11:45 am during an interview with the Director of Nursing (DON), she stated when the facility receives hospital orders, the nurses are to contact a facility provider to see if the facility provider agrees with the hospital recommendation. J. On 07/24/25 at 3:20 pm during an interview with the Medical Director (MD), he stated that he does not think R #9's scalp became infected because the staples were left in too long, but he expects the nursing facility staff to follow hospital orders because those are orders from a physician. The MD confirmed that R #9's hospital order was for R #9's staples to be removed within 7 to 10 days, and the facility should have followed those orders. R #11: K. Record review of R #11's face sheet revealed R #11 was admitted into the facility on [DATE]. L. Record review of R #11's physician orders dated 02/07/24 revealed R #11 was prescribed Xarelto (anticoagulant) 2.5 mg (milligrams), give one tablet by mouth twice a day related to heart disease. There was no order present for monitoring R #11 for complications (bruising, bleeding, pain, swelling, and dizziness) related to anticoagulant use.M. Record review of R #11's care plan dated 05/06/25 revealed that R #11 received anticoagulant medication related to heart disease. R #11's interventions included the facility staff monitor/document/report to a provider any signs or symptoms of anticoagulant complications. Nursing staff were to review R #11's medication list for adverse interactions as well. N. Record review of R #11's nursing progress notes dated 04/17/25 through 04/20/25 revealed the following: 04/17/25 at 11:40 pm: R #11 was yelling at a Certified Nursing Assistant (CNA) and following the CNA throughout the unit. R #11 proceeded to punch Registered Nurse (RN) #3 in the chest and when RN #3

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	07/24/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a program of activities sufficient to meet each resident's capabilities, interests and needs, for 1 (R # 5) of 3 (R #s 1, 2 and 5) residents reviewed for activities. This deficient practice has the potential to cause residents feelings of boredom, isolation and depression. The findings are: A. On 07/22/25 at 11:17 am during an interview with R #5 he stated that he would like to be integrated back into the community. He further stated that there are no facility outings scheduled by the facility and he would like to go outside to walk but he was told he was not to leave the facility without someone accompanying him. R #5 feels frustrated because he is not able to exercise his rights to be able to leave the facility to go to the store or to walk around the facility grounds. B. Record review of Activity assessment dated [DATE] revealed: Page 2 question 7. Go outside for fresh air when the weather is nice: 1) Very Important. C. Record review of Minimum Data Set (MDS-Nursing Resident Assessment and care screening) dated 06/17/25 revealed: Section C-Cognitive Patterns- BIMS score of 15 (brief interview for mental status with scoring 00 through 15. 15 being the highest score- indicating that the individual's cognitive abilities are intact.) D. Record review of R #5's care plan dated 06/21/25 revealed [name of R #5] stated that he went to the store to buy new pair of shoes and returned to the nursing facility. Interventions: encourage resident to let staff know when he wants to go out to purchase items. E. On 07/23/25 at 12:37 pm during an interview with the Director of Nursing (DON) she stated that R #5 was not safe to go out on his own because he had some medical issues that prevented him from being safe and making sound decisions. R #5 is not in agreement that he needs staff to participate with him when he wants to walk to the store or go for a walk. He has not been deemed incompetent. DON further stated that the facility should be able to offer someone to accompany R #5 and that there's not always someone available. DON confirmed R #5 has a BIMS score of 15- cognitively intact. [NAME] further confirmed that there has not been any transportation available for the use of activity outings for the residents in at least 2-3 months. F. On 07/23/25 at 1:15 pm during an interview with the Activities Assistant (AA) she stated R #5 is alert and oriented and able to make his needs known. The AA further stated that R #5 is not allowed to leave the facility because it is not safe and if he were to be seen leaving the front door staff is to bring him back in. The AA further stated that facility outings had not occurred since the facility van had been out of service (2-3 months). G. On 07/23/25 at 11:35 am during an interview with the Activities Director (AD) she stated that the facility van has not been operational for a few months, so they have not been able to take the residents on outings or been able to take them shopping or on rides. When asked about R #5 she stated that he does like to go on outings and likes to go outdoors, but the activities program has not included outings for a while because of the broken van. The AD is hoping to get a van soon to be able to resume the outings and the van rides. H. Record review of the posted July 2025 activity calendar revealed: 6 scheduled outings. All scheduled outing did not occur this month. I. Record review of printed May 2025 activity calendars revealed: 10 scheduled outings. All scheduled outing did not occur this month. J. On 07/23/25 during an interview with R #1 and R #2 they stated that the facility has not had any facility outings for two or three months due to the van not being operational. They both stated that some of the residents are upset about not being able to go on outings. R #2 confirmed that R #5 gets very upset about not being able to go for walks or on outings to the store.

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	07/24/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	07/24/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents received the necessary treatment and services to prevent the development and worsening of pressure wounds (also called a pressure injury/pressure ulcer; skin damage which results from unrelieved pressure on the body) for 1 (R #15) of 1 (R #15) resident reviewed when staff failed to: Monitor for changes in R #15's coccyx (tailbone area; base of spine) pressure ulcer and timely notify the provider (physician and/or Nurse Practitioner) of R #15's pressure ulcer worsening and development of new pressure wound.Document and monitor wound progress (that includes measurements; to track effectiveness of wound care treatments and to prevent the progression of pressure ulcers) for R #15, so any pressure ulcer changes can be managed and/or treated without delay. These deficient practices likely resulted in R #15's pressure ulcer worsening with necrotic tissue (death of cells in tissue due to disease, injury, or failure of the blood supply) which required referral to an out of facility wound care clinic for advanced wound care treatment not available in the facility. The findings are: A. Refer to F0580 for related findings for R #15. B. Record review of R #15's face sheet revealed R #15 was admitted into the facility on [DATE] with a Pressure Ulcer of Sacral Region (area at the bottom of the spine), Stage 4 (deep wounds that may impact muscle, tendons, ligaments, and bone). C. Record review of R #15's physician orders dated 04/29/25 revealed, wound to coccyx cleanse with normal saline, cover wound bed with collagen hydrogel (wound care product to create moist environment for healing), pack with normal saline wet gauze, cover with dry dressing. One time a day for wound care. Physician order discontinued on 05/14/25.D. Record review of R #15's physician orders dated 05/15/25 revealed, wound to coccyx- cleanse with wound cleanser or normal saline, apply calcium alginate with silver to wound bed, cover with silicone dressing, and monitor for any signs or symptoms of infection every day shift for wound care. Physicians order was discontinued on 06/20/25.E. Record review of R #15's physician orders dated 06/20/25 revealed, wound to coccyx- cleanse with wound cleanser or normal saline, apply calcium alginate with silver to wound bed, cover with silicone dressing, and monitor for any signs or symptoms of infection every day shift for wound care.F. Record review of R #15's Weekly Wound Progress Form (form completed by facility Registered Nurse Treatment Nurse (RNTN)- Wound Care Nurse) dated 04/30/25 through 07/07/25 revealed the following:04/30/25: R #15's coccyx pressure ulcer identified on 04/28/25, was measured to have a length of 5.0 cm (centimeters), width of 3.0 cm, and a depth of 2.2 cm. Notes stated, Wound is healing well. 05/06/25: R #15's coccyx pressure ulcer was measured to have a length of 4.5 cm, width of 3.0 cm, and a depth of 2.0 cm. Notes stated, Wound is healing well.05/15/25: R #15's coccyx pressure ulcer was measured to have a length of 5.0 cm, width of 3.2 cm, and a depth of 2.8 cm. Notes stated, Wound has gotten larger, more drainage, and foul odor. Calcium alginate (specialized wound dressing to prevent infection) with silver added to wound order.05/21/25: R #15's coccyx pressure ulcer was measured to have a length of 5.0 cm, width of 3.5 cm, and a depth of 3.0 cm. Notes stated, Wound is healing well. Mo foul odor to the wound. 05/28/25: R #15's coccyx pressure ulcer was measured to have a length of 5.0 cm, width of 5.0 cm, and a depth of 3.3 cm. Notes stated, Wound has gotten larger.06/03/25: R #15's coccyx pressure ulcer was measured to have a length of 5.0 cm, width of 5.0 cm, and a depth of 3.0 cm. Notes stated, Wound is healing well.06/20/25: R #15's coccyx pressure ulcer was measured to have a length of 5.0 cm, width of 4.8 cm, and a depth of 2.9 cm. Notes stated, Wound is healing well.06/24/25: R #15's coccyx pressure ulcer was measured to have a length of 6.0 cm, width of 5.0 cm, and a depth of 2.5 cm. Notes stated, Wound is healing slowly.07/07/25 #1: R #15's coccyx pressure ulcer was measured to have a length of 6.0 cm, width of 6.0 cm, a depth of 2.0 cm, and 3.0 cm tunneling of the wound. Notes stated, Necrotic tissue. Orders for wounds to be seen by wound clinic sent in. Wound progress form indicated that R #15's coccyx pressure ulcer grew wider by 1 cm with 3 cm tunneling and necrosis between 06/24/25 and 07/07/25. 07/07/25 #2: R #15's left gluteal fold (horizontal skin crease that forms below the buttocks) pressure ulcer identified on 06/28/25, was measured to have a length of 5.0 cm, width of 6.0 cm, and a depth of 0.1 cm. Notes stated, Orders for wounds to be seen by wound clinic sent in.No weekly wound progress form was completed between 06/03/25 through 06/20/25, and 06/24/25 through 07/07/25. G. Record review of R #15's Weekly Skin Checks (completed by facility nursing staff) dated 05/02/25 through 07/03/25 revealed the following:05/02/25 at 5:23 am: R #15's coccyx pressure ulcer was not documented.05/09/25 at 1:39 am: R #15's coccyx pressure ulcer was healing well and dressed daily. 05/10/25 at 11:41 am: R #15's coccyx pressure ulcer had

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	07/24/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have competent (aware of each resident's current health status and regular activity) nursing staff that was aware of anticoagulant (blood thinner) use for 1 resident (R #11) of 1 resident's (R #11) reviewed for falls. If nursing staff are not aware of anticoagulant medications taken by residents; then this deficient practice is likely to result in medication administration errors, the lack of monitoring of the resident's condition, delays in treatment or interventions, and increased risk of serious injury or complications such as bleeding, following a fall. The findings are: A. Record review of R #11's face sheet revealed R #11 was admitted into the facility on [DATE]. B. Record review of R #11's physician orders dated 02/07/24 revealed R #11 was prescribed Xarelto (anticoagulant) 2.5 mg (milligrams), give one tablet by mouth twice a day related to heart disease.C. Record review of R #11's care plan dated 05/06/25 revealed that R #11 received anticoagulant medication related to heart disease. R #11's interventions included the facility staff monitor/document/report to a provider any signs or symptoms of anticoagulant complications. Nursing staff were to review R #11's medication list for adverse interactions as well. D. Record review of R #11's nursing progress notes dated 04/17/25 through 04/20/25 revealed the following: 04/17/25 at 11:40 pm: R #11 was yelling at a Certified Nursing Assistant (CNA) and following the CNA throughout the unit. R #11 proceeded to punch Registered Nurse (RN) #3 in the chest and when RN #3 raised her arm to block R #11's second punch, R #11 lost her balance and fell on the floor while also hitting her head. R #11 refused to let RN #3 get her vitals and complete a post fall assessment. 04/18/25 at 5:52 am: R #11's daughter called requesting a follow-up from R #11's previous fall. Nurse will inform day nurse to call R #11's daughter, facility provider was also notified. 04/18/25 at 8:34 am: R #11 is alert and oriented times one (indicating R #11 was aware of who they are but with confusion) and denied pain or confusion. R #11 has a hematoma (a solid swelling of clotted blood within the tissues) and bruising to left side of face. R #11 being sent to hospital for x-rays. 04/19/25 at 5:46 pm: Bruising spreading throughout face and head for R #11. E. Record review of R #11's Medication Administration Record (MAR) dated 04/01/25 through 04/19/25 revealed R #11 received Xarelto 2.5 mg every day as ordered. F. On 07/23/25 at 5:35 pm during an interview with Registered Nurse (RN) #3, she stated that when R #11 experienced a fall with her on 04/17/25, she was unaware that R #11 was on an anticoagulant medication. RN #3 also stated that R #11 experienced significant bruising after the fall on 04/17/25 and the amount of bruising on R #11's face looked horrible. RN #3 stated that she would like a list of residents that took an anticoagulant medication so she could be aware of that in case those residents experience a fall. RN #3 confirmed she did not read R #11's care plan and did not know that R #11 took an anticoagulant medication until R #11 fell on [DATE]. G. On 07/24/25 at 9:43 am during an interview with the Nurse Practitioner (NP), she stated that nursing staff should be familiar with the residents and the medications that residents take. The NP confirmed she would expect RN #3 to know that R #11 took an anticoagulant medication. H. On 07/24/25 at 10:26 am during an interview with the Registered Nurse Consultant (RNC), she stated that she would expect the facility nurses to be familiar with the medications that residents take and she would expect that facility nurses would read residents care plans. The RNC confirmed RN #3 should have known about R #11's anticoagulant medication use. I. On 07/24/25 at 3:37 pm during an interview with the Medical Director (MD), he confirmed that he would expect that RN #3 would have known that R #11 was taking an anticoagulant medication prior to R #11's fall on 04/17/25.

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	07/24/2025

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to utilize Nursing Assistants (NAs) appropriately by using NAs for more than 4 months, on a full-time basis to provide nursing and nursing related services for 2 (NAs #1 and 2) of 3 (NAs #1, 2, and 3) reviewed for staffing.If the facility is staffing NAs for longer than 4 months, then residents are likely to not receive the appropriate care, services and may not meet the needs of all residents.The findings are: NA #1: A. Record review of the facility staffing list reviewed on 07/24/25 revealed NA #1 was hired by the facility on 01/13/25 as a Nurse Aide in Training. B. Record review of the facility staffing schedule dated 07/21/25 through 07/24/25 revealed NA #1 worked on a unit as a Nurse Aide in Training.C. On 07/24/25 at 2:48 pm during an interview with NA #1, she stated that she just became a Certified Nursing Assistant (CNA) about one week ago, but prior to that, she was working at the facility as a Nurse Aide in Training for longer than 120 days. NA #2: D. Record review of the facility staffing list reviewed on 07/24/25 revealed NA #2 was hired by the facility on 10/30/24 as a Nurse Aide in Training. E. On 07/24/25 at 3:57 pm during an interview with the Director of Nursing (DON), she confirmed both NA #1 and NA #2 were working in the facility as NAs for longer than 120 days and they shouldn't have.