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	03/10/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interviews, the facility failed to ensure psychotropic medication (medication used to treat mental health conditions) consent forms were signed by the resident or resident representative prior to medication administration for 1 (R #1) of 3 (R #1, #2, and #3) residents reviewed for unnecessary psychotropic drugs. This deficient practice is likely to put residents at increased risk for undesirable side effects (including but not limited to increased drowsiness, insomnia, fatigue, sexual dysfunction) associated with the use of these medications.The findings are:A. Record review of R #1's physician orders revealed the following: 04/24/25: Lorazepam (anti-anxiety medication) 0.5 mg (milligram), as needed every four hours for anxiety. Discontinued 06/27/25.09/12/25: Lorazepam 0.5 mg, as needed every four hours for anxiety. Discontinued 09/17/25.09/17/25: Lorazepam 0.5 mg, as needed every four hours for anxiety. Discontinued 09/26/25.01/05/26: Lorazepam 0.5 mg, as needed every four hours for anxiety. Discontinued 01/06/26.01/06/26: Lorazepam 0.5 mg, as needed every four hours for anxiety. Discontinued 01/19/26.02/27/26: Lorazepam 0.5 mg, as needed every four hours for anxiety. Discontinued 03/02/26.04/24/26: Haldol (antipsychotic medication) 0.5 mg, as needed for behavioral disturbances. Discontinued 05/29/25.11/05/25: Seroquel (an antipsychotic medication) 25 mg, give two times a day for depression. Discontinued 01/05/26.B. Record review of R #1's Electronic Health Record (EHR) revealed R #1's Psychoactive Medication Consent Form was completed on 01/06/26 for the medication Lorazepam no other Medication Consent Form were available or completed for R #1's Seroquel and Haldol or Lorazepam use. C. On 03/09/26 at 12:35 pm during an interview with the Director of Nursing (DON), she confirmed Psychoactive Medication Consent forms should have been completed prior to administering Lorazepam, Haldol and Seroquel to R #1 but that did not occur.

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 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** Based on record review and interviews, the facility failed to notify R #1's daughter and the hospice nurse for 1 (R #3) of 3 (R #1, 2 and 3) resident reviewed for falls. This deficient practice is likely to result in family and the hospice not being able advocate for residents and residents being at further risk of injury. The findings are: A. On 03/09/26 at 12:43 pm during an interview with R #1's daughter, she stated that she had received a call from [name of local hospital] on 02/28/26 at 5:30 am and was advised that they needed her permission to treat her mother [R #1]. Daughter further stated that she had not been notified by the facility that her mother had had a fall and had been taken to the hospital. R #1's daughter stated she would have liked to have received a call from the facility about her mother's fall and felt as if they did not care. Daughter was not notified until her mother returned back to the facility from the hospital. B. On 03/09/26 at 4:12 pm during an interview with Hospice Director of Nursing (HDON), she stated the facility had not notified the hospice nurse until after R #1 had returned back to the facility from the emergency room on [DATE]. HDON further stated that at that time hospice nurse had gone to the facility to assess R #1.C. On 03/10/26 at 10:14 am during an interview with Licensed Practical Nurse (LPN) #2, she stated, that she had notified hospice at approximately 9:00 am the morning of 02/28/26 after the fall. (fall occurred between 5:00-5:30 am). LPN #2 further stated that once hospice is notified hospice is responsible of notifying the family it is not the facility's responsibility to notify the family.D. On 03/09/26 at 12:35 pm during an interview with the Director of Nursing (DON) she stated that the facility should notify the family, the physician and hospice if the resident is on hospice. DON was unable to confirm that family or hospice had been notified.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide a Facility Initiated Report (mandatory self-initiated facility report of an incident) and a five day follow up report to the State Survey Agency (SSA) after a fall with injury for 1(R#1) of 1 (R #1) resident reviewed for incidents,This deficient practice is likely to result in the State Survey Agency (SSA) not being aware of facility incidents and being unable to assure residents safety. The findings are:A. On 03/09/26 at 12:43 pm during an interview with R #1's daughter she stated that she received a call from [name of local hospital] informing her that her mother had been brought to the hospital and needed her permission to treat her mother for a laceration she had obtained to her forehead due to a fall at the facility. B. Record review of progress notes dated 02/28/26 at 5:23 pm revealed, R #1 experienced a fall this morning resulting in a 7.0 cm x 2.0 cm (cm-centimeter- unit of measure) laceration to the right side of her forehead. R #1 was transported to [name of local hospital].C. 03/09/26 at 12:40 pm during an interview with the facility Administrator he stated that he was aware of the incident with R #1 and any fall with injury should be reported to the state agency. Administrator confirmed R #1's fall had not been reported to the state agency and should have been.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to thoroughly investigate a fall with injury involving 1 (R #1) of 1 (R #1). This deficient practice is likely to result in residents not getting the treatment/care needed if the facility is not thoroughly investigating incidents. The findings are:A. On 03/09/26 at 12:43 pm during an interview with R #1's daughter she stated that she received a call from [name of local hospital] informing her that her mother had been brought to the hospital and needed her permission to treat her mother for a laceration she had obtained to her forehead due to a fall at the facility. B. Record review of progress notes dated 02/28/26 at 5:23 pm revealed, R #1 experienced a fall this morning resulting in a 7.0 cm x 2.0 cm (cm-centimeter- unit of measure) laceration to the right side of her forehead. R #1 was transported to [name of local hospital].C. On 03/09/26 at 12:35 pm during an interview with Director of Nursing (DON) she stated that an investigation had not been conducted for the fall R #1 had on 02/28/26 and was unable to confirm the exact time of incident nor was she able to locate the change in condition for the incident (R #1's fall with injury). DON was also unable to confirm who had witnessed the fall or how it occurred. DON stated that the incident should have been investigated and reported to the State Agency and it was not. D. On 03/10/26 at 3:11 pm during an interview with DON, she stated, The nurse assigned is responsible for notifying family, physician and DON when there is any change of condition including falls with injuries. DON confirmed that she did not conduct an investigation for the R #1's fall and she should have. DON further stated that R #1's medical records was not complete and notes were not through as to what occurred during R #1's incident. E. On 03/10/26 at 10:14 am during an interview with Licensed Practical Nurse (LPN) #2, she stated, that incident with R #1 was not witnessed by her, she heard a loud noise and heard the Certified Nurse Aide (CNA) #1 yelling that R #1 was on the floor. LPN #2 stated that she went around the nurses' station and witnessed R #1 on the floor and had a laceration on her forehead. LPN proceeded to call [name of local hospital] and had R #1 sent out via ambulance to local hospital. LPN #2 stated she had written a progress note in R #1's medical chart as to what she had witnessed. LPN #2 confirmed that she had not conducted an investigation. F. On 03/11/26 at 11:10 am during an interview with Registered Nurse (RN) #1 he stated that he did not witness R #1's fall, RN #2 was giving report to the oncoming nurse and heard the certified Nurse Aide yell and he rushed to witness R #1 on the floor on her side face down and bleeding quite a bit. RN #1 applied gauze to slow down the bleeding and was R #1 returned to her wheelchair and taken to her room and later sent out to [name of local hospital] by the oncoming nurse. RN #1 stated he had not documented incident or what he had witnessed in R #1's medical record.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review and interview, the facility failed to accurately complete quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessments for 1 (R #1) of 3 (R #1, #2, and #3) residents reviewed for assessment accuracy and completion. This deficient practice is likely to result in residents not receiving care and treatment that meet their current needs. The findings are:A. Record review of R #1's electronic health record (EHR) revealed a quarterly MDS assessment for R #1 was due to be completed by 02/16/26.B. On 03/09/26 at 12:35 pm during an interview, the Director of nursing (DON) confirmed the MDS quarterly assessment was due 02/16/26 and it was not completed and it should have been completed by the due date.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, the facility failed to ensure that the Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) quarterly assessment was electronically transmitted within the required 14-day timeframe for 1 (R #1) out of 3 (R #1, #2, and #3) residents reviewed for MDS transmittal requirement. This deficient practice is likely to hinder the ability of regulatory bodies to oversee resident care and prevents the facility from accurately tracking clinical trends or declines in a resident's condition over time.The findings are: A. Record review of R #1's MDS log revealed the Quarterly Assessment with an Assessment Reference Date (ARD) of 02/16/26 had not been transmitted.B. Record review of the Quarterly Assessment revealed, the assessment remained in Draft (not completed or transmitted) status in the facility's software and had not been encoded or transmitted.C. On 03/09/26 at 12:35 pm during an interview, the Director of nursing (DON) confirmed the MDS quarterly assessment was due 02/16/26 and it was not transmitted electronically. The DON also stated all MDS assessment should be transmitted timely (within the required 14-day timeframe), and it did not happen.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a comprehensive and accurate assessment was completed for 1 (R #1) out of 3 (R #1, #2, and #3) residents reviewed upon readmission to the facility following an acute care hospital stay. This deficient practice is likely to not accurately calculate the resident's Risk Score for skin breakdown or falls.The findings are:A. Record review of the Electronic Health Record (EHR) revealed no complete head to toe assessment was completed when R #1 returned from the hospital on [DATE].B. On 03/10/26 at 3:17 pm during an interview with the Director of Nursing (DON), she confirmed R #1 was not assessed upon arrival from the hospital on [DATE]. The DON stated all residents sent out to the hospital must be assessed (including head to toe skin assessment) upon arrival/admission to the facility and it did not happen.