

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 12/12/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview, the facility failed to report an incident of possible neglect to the State Agency for 1 (R #1) of 3 (R #1, R #2 and R #3) residents reviewed for abuse and neglect. If the facility fails to report allegations to the State Agency, then the State Agency is unable to ensure residents are free from abuse and neglect. The findings are:A. On 10/20/25 at 12:00 pm during interview with Director of Nursing (DON), she stated that R #1 had an incident during care. DON stated that on 10/03/25 she became aware that R #1 was complaining of more pain than usual and that her knee was swollen. DON stated she began to investigate and learned that the nurse who was providing care to R #1 on 09/25/25 was moving R #1 about in bed to provide wound care, during this time, the nurse heard a loud pop. DON confirmed the nurse did not report this incident to her (DON) or to the medical provider. DON confirmed the incident was not documented in R #1's medical record. DON stated that her expectation was for any incidents to be reported to administration, documented in the residents medical chart and an incident report should have been completed. B. Record review of facility's self reports to State Agency dated 09/25/25 to 10/20/25 revealed no incidents had been reported for R #1 during that time period.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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