

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Ladera Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5901 Ouray Road NW Albuquerque, NM 87120	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>49196</p> <p>Based on observation and interview, the facility failed to provide a comfortable, homelike environment for 2 (R #5 and R #7) of 3 (R #5, R #6, and R #7) residents reviewed for resident rights by failing to ensure the hallway remained free of a persistent urine smell. This deficient practice could lead to residents feeling disrespected, uncomfortable, and embarrassed. The findings are:</p> <p>A. On 03/19/2024 at 9:45 AM during an observation, the facility's north hallway near the nurse's station had a strong smell of urine.</p> <p>B. On 03/19/2024 at 11:05 AM during an interview with R #5, she stated the hallways of the facility always smelled like urine, and it got much stronger on the weekends. She stated it felt gross to smell that.</p> <p>C. On 03/19/2024 at 1:29 PM during an interview with R #7's family member, she stated, that during R #7's stay at the facility from 02/24/24 to 03/07/24, there was constantly a very strong smell of urine and feces in the facility, especially on the right (north) hall. She added she and her family member felt very uncomfortable and disgusted by the smell.</p> <p>D. On 03/20/2024 at 2:45 PM during an observation, the facility's north hallway near the nurse's station had a strong smell of urine.</p> <p>E. On 03/20/24 at 3:22 PM during an interview with a facility housekeeper (HK), she stated they were aware of the strong urine smell in the hallway and suspect that it came from the resident rooms. She said they cleaned the rooms once daily and as requested with an odor removing spray, but the smell persisted.</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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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>49196</p> <p>Based on observation, interview, and record review, the facility failed to provide an activities program designed to meet the interest and preferences of each resident for 3 (R #4, R #5, and R #6) of 3 (R #4, R #5, and R #6) residents reviewed for activities. This deficient practice could result in residents feeling less connected to their peers, having lower self-esteem, and experiencing a decline in psychosocial well-being. The findings are:</p> <p>R #4</p> <p>A. Record review of R #4's Recreation Comprehensive Assessment, dated 11/15/2023, revealed the resident felt it was very important that he participated in his favorite activities, but the assessment did not include a list of the resident's preferred activities.</p> <p>B. On 03/19/2024 at 9:55 AM, an observation of the facility's day room revealed a large whiteboard where staff list the current month's activities. Further observation revealed the whiteboards was blank.</p> <p>C. On 03/19/2024 at 10:16 AM during an interview, R #4 stated he enjoyed socializing with other residents, but he did not know when or what the next group activity would be. He added that sometimes the Activities Assistant (AA) delivered a monthly event calendar to his room, but not consistently. He motioned in the direction of the blank whiteboard in the day room and shrugged.</p> <p>R #5</p> <p>D. Record review of R #5's Recreation Comprehensive Assessment, dated 02/05/2024, revealed the resident felt it was very important that she was able to participate in her favorite activities, but the assessment did not include a list of the resident's preferred activities.</p> <p>E. Record Review of the facility's activity calendar, dated March 2024, revealed an activity titled Prepare Your Seedling scheduled for 11:00 AM on 03/19/2024.</p> <p>F. On 03/19/2024 at 11:05 AM during an observation of the activity room, seven residents sat in the room, but the Prepare Your Seedling activity scheduled for 11 AM did not occur.</p> <p>G. On 03/19/2024 at 11:15 AM during an interview, R #5 stated the AA had to go to the store, so the scheduled activity did not happen. R #5 stated she was disappointed and looked forward to using the flowerpot she painted the week before for today's activity. R #5 stated she was worried, because the AA's last day is in two days. R #5 stated she did not know if there would be any more activities. R #5 stated she wished there was more to do on the weekends and more activities that were morale boosting, like the Zumba class.</p> <p>R #6</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>H. Record review of R #6's Recreation Comprehensive Assessment, dated 09/21/2023, revealed the resident felt it was very important that he was able to participate in his favorite activities, but the assessment did not include a list of the resident's preferred activities.</p> <p>I. Record Review of the facility's activity calendar, dated March 2024, revealed an activity titled Shop and Restock scheduled for 12:00 PM on 03/21/24.</p> <p>J. On 03/20/2024 at 10:18 AM during an interview, R #6 stated he liked to socialize with other residents and usually attended the morning coffee activity. He stated he wished there were more opportunities for group activities. He added he would enjoy more time outdoors and community trips to go shopping. He also stated he wanted to see more lively dancing and music activities, such as the Zumba class. R #6 stated, because it's depressing here, and we (the residents) need more positivity. R #6 stated the Shop and Restock activity was not for residents to go shopping, and there were not any community shopping trips or outings for the residents.</p> <p>K. On 03/20/2024 at 1:48 PM during an interview, AA stated she was the only activities staff member since 03/01/2024, and she was not able to do all of the activities listed on the schedule. The AA stated she frequently had to reschedule activities to fit them into her work hours. The AA stated she was not able to update the whiteboard in the day room with the activities for March. The AA stated she did not work on weekends, and the only activities available during that time were the scheduled religious services on Sundays. She stated the residents often asked for community outings and shopping trips, but the facility did not allow the use of their transportation vehicles for activities. The AA stated residents provided the AA with their shopping list and money approximately twice a month, and this was listed as Shop and Restock on the activities calendar. The AA also stated the attendance for most activities was between 5 and 15 residents, and it was usually the same residents each day.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40795</p> <p>Based on record review and interview, the facility failed to:</p> <ol style="list-style-type: none"> 1. Monitor blood sugar levels, and; 2. Notify the physician when a resident's blood sugar dropped below 70 milligrams (mg) / decilitre (dL; A blood sugar reading below 70 mg/dL is considered low and dangerous. A normal level is 90 to 130 mg/dL.) <p>This deficient practice affected 2 (R #6 and R #11) of 3 (R #6, R #8, and R #11) residents reviewed for diabetic management.</p> <p>This deficient practice could likely result in residents feeling physically ill and unsatisfied with the care received.</p> <p>The findings are:</p> <p>Findings for R #11:</p> <p>A. Record review of R #11's face sheet revealed R #11 admitted to the facility on [DATE] with the pertinent diagnosis of type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy) with hyperglycemia (when blood sugar falls below a healthy level). Further review revealed R #11 discharged on [DATE].</p> <p>B. Record review of a grievance submitted by R #11's husband, dated 01/02/24, revealed the husband stated nursing did not monitor R #11's blood sugar, and he found it to be very low three times. [R #11 had a medical device that constantly read the resident's blood sugar and sent the readings to the family member's personal cell phone.] Further review revealed the grievance was resolved on 01/03/24 when the unit manager put in an order for staff to check R #11's blood sugar.</p> <p>C. Record review of R #11's physician orders revealed the following pertinent orders:</p> <ol style="list-style-type: none"> 1. Dated 12/24/23- 01/11/24, Lantus SoloStar subcutaneous solution pen-injector (a long acting insulin that is used to manage the body's blood sugar), 100 unit/milliliters (ml). Inject 20 unit subcutaneously (under the skin) two times a day for diabetes mellitus (DM). 2. Dated 12/24/23- 01/23/24, HumaLOG injection solution (a short acting insulin that is often used on a sliding scale to rapidly reduce a patient's blood sugar), 100 unit/ml. Inject 25 units subcutaneously before meals for DM; 3. Dated 12/26/23- 01/23/24, Hypoglycemia Protocol - observe for signs and symptoms of hypoglycemia (low blood sugar), as needed. If blood glucose is less than 70 mg/dl or ordered low parameter follow hypoglycemia protocol. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Dated 12/26/24- 01/23-24, Insta-Glucose gel,77.4 %. Give one dose by mouth as needed for blood glucose or blood sugar less than 70 mg/dL. Hold all diabetic medications until provider authorizes resumption. Remain with patient. Keep patient in bed or chair for safety. Repeat blood glucose check in 15 minutes.</p> <p>D. Record review of the Medication Administration Record, dated December 2023, revealed the following:</p> <p>1. For the order dated 12/24/23- 01/11/24, Lantus SoloStar, staff did not record blood sugar measurements from 12/24/23-12/31/23.</p> <p>2. For the order dated 12/24/23- 01/23/24, HumaLOG, staff did not record blood sugar measurements 12/24/23-12/31/23.</p> <p>E. Record review of the Medication Administration Record, dated January 2024, revealed the following:</p> <p>1. For the order dated 12/24/23- 01/11/24, Lantus SoloStar, staff did not record blood sugar measurements from 01/01/24-01/03/24.</p> <p>2. For the order dated 12/24/23- 01/23/24, HumaLOG, staff did not record blood sugar measurements from 01/01/24-01/02/24.</p> <p>F. Record review of R #11's blood sugar measurements, under the Vitals tab in the electronic health record, revealed the following:</p> <p>1. On12/25/24 at 1:16 am, staff documented one blood sugar reading for the day,</p> <p>2. On 12/26/23, staff did not document the resident's blood sugar reading,</p> <p>3. On 12/27/23, staff did not document the resident's blood sugar reading,</p> <p>4. On 12/28/23, staff did not document the resident's blood sugar reading,</p> <p>5. On 12/29/23, staff did not document the resident's blood sugar reading,</p> <p>6. On 12/30/23 at 6:33 pm, staff documented one blood sugar reading for the day,</p> <p>7. On 12/31/23, staff did not document the resident's blood sugar reading,</p> <p>8. On 01/01/24, staff did not document the resident's blood sugar reading,</p> <p>9. On 01/02/24, staff did not document the resident's blood sugar reading,</p> <p>10. On 01/03/24 at 1:00 pm- and at 6:27 pm, staff documented two blood sugar readings for the day,</p> <p>11. On 01/07/24 at 11:16 am, 5:10 pm, and at 6:48 pm, staff documented three blood sugar readings for the day,</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12. On 01/10/24 at 9:30 am, staff documented the resident's blood sugar was 57.0 mg/dl (very low).</p> <p>13. On 01/17/24 at 12:30 pm and at 6:28 pm, staff documented two blood sugar readings for the day.</p> <p>Findings for R #6:</p> <p>G. Record review of R #6's face sheet revealed R #6 was admitted to the facility on [DATE] with pertinent diagnosis of type 2 diabetes mellitus.</p> <p>H. Record review of R #6's physician orders revealed the following pertinent orders:</p> <p>1. Dated 09/19/23-present, Hypoglycemia Protocol- observe for signs and symptoms of hypoglycemia, as needed. If blood glucose is less than 70 mg/dl or ordered low parameter follow Hypoglycemia Protocol,</p> <p>2. Dated 09/19/23- present, Insta-Glucose gel 77.4 %. Give one dose by mouth as needed for blood glucose less than 70. Hold all diabetic medications until provider authorizes resumption. Remain with patient. Keep patient in bed or chair for safety. Repeat blood glucose check in 15 minutes,</p> <p>3. Dated 10/04/23- 02/26/24, Insulin Glargine-yfgn (a long acting insulin that is used to manage the body's blood sugar) subcutaneous solution pen-injector, 100 unit/ml. Inject 45 units subcutaneously at bedtime for uncontrolled DM,</p> <p>4. Dated 10/05/23- 02/26/24 Insulin Glargine-yfgn subcutaneous solution pen-injector, 100 unit/ml. Inject 45 units subcutaneously one time a day at 7:00 am for uncontrolled DM.</p> <p>I. Record review of R #11's blood sugar measurements, under the Vitals tab in the electronic health record, revealed the following:</p> <p>1. On 02/10/24 at 10:22 pm, staff documented the resident's blood sugar was 66.0 mg/dL,</p> <p>2. On 02/18/24 at 6:07 pm, staff documented the resident's blood sugar was 63.0 mg/dL.</p> <p>J. Record review of R #11's nursing notes revealed staff did not document they notified the physician of R #6's low blood sugar reading on 02/10/24 or on 02/18/24.</p> <p>Staff interview:</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>K. On 03/20/24 at 2:40 pm, during an interview with the Unit Manager Registered Nurse (UMRN), she stated R #11 had a Dexcom sensor (medical device that constantly monitors a patient's blood sugar) in her arm which could sometimes be inaccurate. The UMRN stated the resident's husband received an alert in the middle of the night that indicated the resident's blood sugar dropped into low numbers. The UMRN stated staff did not check R #11's blood sugar from 12/24/23-01/02/24. She stated R #11 was admitted to the facility on the holiday weekend, and management nursing staff were not working holiday hours. The UMRN stated they were not able to do a chart check to ensure the orders were accurate and contained a request for blood sugar readings before administering the sliding scale insulin. She also stated that if a R #11 was ordered to receive a sliding scale insulin, nursing staff should collect a blood sugar reading before meals and at bedtime (four times a day). She stated that on 02/10/24, nursing staff should have rechecked R#6's blood sugar 15 minutes after assisting him to ensure it stabilized above 70 mg/dL. She also stated the nursing staff should have notified the physician when R #6's blood sugar dropped below 70 on 02/10/24 and 02/18/24 .</p>		