STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325037	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ladera Center	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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 49196 Based on record review and interview, the facility failed to notify the medical provider (Physicians and Nurse Practitioners) of a change in condition in which a resident with a history of myocardial infarction (MI; heart attack) reported chest pain for 1 (R #112) of 1 (R #112) residents reviewed for provider notification. If the facility fails to notify the provider of intermittent (not continuous) chest pain for a resident with prior history of MI (a major risk factor for having another MI), then it could likely delay the resident receiving necessary testing to determine if the resident requires life-saving medical intervention. This deficient practice likely contributed to the passing of R #1. The findings are: A. Record review of R #112's facesheet revealed R #112 admitted to the facility on [DATE] with the following list of diagnoses (not all-inclusive): - Diabetes mellitus (a chronic disease that occurs when the body is unable to control blood sugar levels). - Sepsis (a life-threatening extreme immune system response to infection or injury which can cause inflammation, blood clots, and damaged blood vessels reducing the blood flow and oxygen delivered to the body's organs). - Acute respiratory failure (inability to maintain adequate oxygenation in the body). - Atrial fibrillation (a type of irregular heartbeat that occurs when the electrical signals in the heart's upper chambers fire quickly and out of rhythm). - Myocardial infarction type 2 (a type of heart attack that occurs when the supply of oxygen to the heart does not meet the heart's demand). - Hypertension (high blood pressure). - Congestive heart failure (a serious long term condition that occurs when the heart cannot pump enough blood to the meet the body's needs). (continued on next page)

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

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

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 10/28/2024
NAME OF PROVIDER OR SUPPLIER Ladera Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5901 Ouray Road NW Albuquerque, NM 87120	

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	B. Record review of R #112's admission Minimum Data Set assessment (MDS; a federally mandated comprehensive assessment of each resident's functional capabilities that helps nursing home staff identify health problems), dated [DATE], revealed staff documented the following for the look back period (The time period over which staff observe a resident to capture the resident's condition or status for the MDS assessment. Unless otherwise stated, the look back period is seven days, and only those occurrences during the look back period will be captured on the MDS.): - Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 14, cognitively intact. - Active diagnoses of atrial fibrillation, heart failure, and hypertension. - R 112's pain was rare or non-existent. - R 112's ability to express ideas and wants was usually understood. Resident had difficulty communicating some words or finishing thoughts but was able if prompted or given time. - R 112's was able to understand others. Resident missed some part/intent of the message but comprehended most conversation. - No behaviors. - R 112's prognosis (life expectancy) was greater than 6 months. C. On [DATE] at 4:20 PM during an interview, CNA #2 stated that on [DATE] she checked on R #112 around 4 PM when he reported to her that his chest was hurting. CNA #2 immediately notified the nurse (LPN #1) who assessed the resident and took vital sign measurements. D. Record review R #112's nursing progress note, dated [DATE] at 4:01 PM and authored by Licensed Practical Nurse (LPN) #1, revealed the Certified Nursing Assistant (CNA) reported the resident complained of chest pain. Staff obtained the resident's vital signs as follows: ,d+[DATE] (blood pressure should be , d+[DATE] or lower); 88 (normal pulse for adults is between 60 and 100); 22 (normal respiratory rate for a resting adult is between 12 and 20); 98.6 (the usual body temperature is generally considered to be between 97 and 99 degrees fahrenheit); on 2.5 liters (L) of oxygen. Staff assessed the resident, and he did not have any complaints at the time. R #112's color was pale, skin was cool, no diaphoresis (sweating). The resident answered questions appropriately. E. On [DATE] at 2:04 PM and 4:02 PM during an interview, LPN #1 stated the medical provider was not notified about R #112's initial report of chest pain, because he was at his baseline when she assessed him. LPN #1 stated she did not ask R #112 about his chest pain (type, duration, frequency), because he was not actively experiencing it. She stated she could not recall whether she considered his cardiovascular history when she decided not to notify the medical provider. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	F. On [DATE] at 1:40 PM during an interview, CNP (Certified Nurse Practitioner) #1 stated he expected to be notified if a resident complained of chest pain, even if the pain was not constant. CNP #1 stated staff should always take chest pains seriously, because residents may need diagnostics, such as an electrocardiogram (EKG; a test that checks for problems with the electrical activity of the heart) or blood tests to rule out a heart attack. He stated a resident with significant cardiovascular history such as R #112 was especially at risk and should be sent to the emergency room (ER) if they experienced chest pain in order to be evaluated by a provider. G. On [DATE] at 1:53 PM during an interview, LPN #2 stated residents who experienced any chest pain or other signs of a heart attack or stroke should be sent to out to the ER, and staff should notify the provider of the change in condition. H. Record review of R 112's nursing progress note, dated [DATE] at 5:00 PM and authored by LPN #1, revealed nursing staff found R #112 in bed without signs of life. Staff initiated cardiopulmonary resuscitation (CPR; an emergency procedure that combines chest compression with artificial ventilation in an effort to manually preserve intact brain function until further measures are taken. EMS (Emergency Medical Service) arrived and continued life-saving measures which were ultimately unsuccessful and discontinued CPR at 5:34 PM. The family, facility administrator, nursing unit manager, and on-call provider were notified. Based on interview and record review, Immediate Jeopardy (IJ) was identified on [DATE] at 11:17 AM to the Administrator and the Director of Nursing, in person. The facility took corrective action by providing an acceptable Plan of Removal (POR) on [DATE] at 4:05 PM. Implementation of the POR was verified onsite on [DATE] with ongoing trainings for staff regarding change in condition and assessment of chest pains, and the facility completed a full sweep of all residents to identify any other resident who may be experiencing a change in condition and required provider notification. After verification of POR on [DATE] at 2:11 PM, the scope and severity was reduced to D. Plan of Removal: Identification/Correction:All residents have the potential to be affected by this alleged deficient practice, if the facility fails to monitor and notify the provider of residents for a change in condition related to chest pain. The following identification/corrections will be completed by [DATE]: Licensed nurses will complete head to toe assessments on current residents residing in the center to determine presence of a medical change in condition. Concentration on residents with the potential for cardiac complications (history of MI, CHF, etc) will be assessed for recent history of chest pain or other signs and symptoms of cardiovascular complications. Identified issues will be reported to the provider for further direction and medical orders. Systematic Measures: The Director of Nursing/designee will educate current staff regarding policy for resident change in condition. The education includes: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Ladera Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5901 Ouray Road NW Albuquerque, NM 87120	

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- Change in condition is a sudden, clinically important deviation from a resident's baseline including physical, mental, or psychosocial status. Nursing assessment should have included description of chest pain, severity and how long pain had lasted. In addition, nurse should have considered the resident's heart history when assessing for chest pain. - All nurses must notify the provider, family and a nurse manager/nurse manager on-call immediately when they identify any change in condition, when the change occurs. If unsure that the residents are having a change, the nurse will consult with the nurse manager or the provider immediately once they have fully assessed the situation and have the information they need. - Nurses will be educated on nurse to nurse shift report that includes any pertinent diagnosis that could put the resident at risk for complications (i.e.: history of MI). The Director of Nursing/designee will begin education [DATE]. As of [DATE], 100% of currently scheduled staff have been educated on this policy. Any staff member that is not on the current schedule as of [DATE], is on leave of absence (FMLA), vacation, or PRN staff will be educated prior to returning to their next shift. New hires/agency staff will be educated on the above during orientation. Current agency staff are being educated on the above information, and will continue to be educated by the facility human resources and mentor as part of the orientation process, prior to their first shift. The Director of Nursing/designee will review resident progress notes, orders and nursing dashboard during the morning clinical meeting to determine if residents noted change in condition identified, process followed, and monitoring occurred. Quality Assurance and Monitoring the Director of Nursing/designee will audit progress notes 5 days per week in morning clinical meeting to monitor for timely notification of change in conditions. Administrator and/or designee will bring results of audits to QAPI committee for further recommendations based on tracking and trending presented monthly for the next 3 months or until ongoing compliance is achieved. The QAPI committee is overseen by the Administrator.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49196 Based on record review and interview, the facility failed to ensure care plans included comprehensive medical history information for 1 (R #112) of 1 (R #112) residents reviewed for comprehensive care plans. This deficient practice could likely result in staff not understanding and implementing the needs and treatments of residents. The findings are: A. Record review of R #112's facesheet revealed R #112 admitted to the facility on [DATE] with the following list of diagnoses (not all-inclusive): -Diabetes mellitus (a chronic disease in that occurs when the body is unable to control blood sugar levels). -Sepsis (a life-threatening extreme immune system response to infection or injury which can cause inflammation, blood clots, and damaged blood vessels reducing the blood flow and oxygen delivered to the body's organs). -Acute respiratory failure (inability to maintain adequate oxygenation in the body). -Atrial fibrillation (Afib: a type of irregular heartbeat that occurs when the electrical signals in the heart's upper chambers fire quickly and out of rhythm). -Myocardial infarction type 2 (a type of heart attack that occurs when the supply of oxygen to the heart does not meet the heart's demand). -Hypertension (high blood pressure). -Congestive heart failure (a serious long term condition that occurs when the heart cannot pump enough blood to the meet the body's needs). B. Record review R #112's nursing progress notes revealed: -Dated [DATE] at 4:01 PM and authored by Licensed Practical Nurse (LPN) #1, revealed the Certified Nursing Assistant (CNA) reported the resident complained of chest pain. Staff obtained the resident's vital signs as follows: ,d+[DATE] (blood pressure should be ,d+[DATE] or lower); 88 (normal pulse for adults is between 60 and 100); 22 (normal respiratory rate for a resting adult is between 12 and 20); 98.6 (the usual body temperature is generally considered to be between 97 and 99 degrees fahrenheit); on 2.5 liters (L) of oxygen. Staff assessed the resident, and he did not have any complaints at the time. R #112's color was pale, skin was cool, no diaphoresis (sweating). The resident answered questions appropriately. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated [DATE] at 5:00 PM and authored by LPN #1, nursing staff found R #112 in bed without signs of life. Staff initiated cardiopulmonary resuscitation (CPR; an emergency procedure that combines chest compression with artificial ventilation in an effort to manually preserve intact brain function until further measures are taken) and was ultimately unsuccessful. EMS (Emergency Medical Service) discontinued CPR at 5:34 PM. The family, facility administrator, nursing unit manager, and on-call provider were notified. C. Record review of R #112's care plan revealed the following: - Prior to [DATE] (date of the resident's death), the care plan did not contain any information regarding the resident's cardiovascular risks or history, symptoms of a cardiovascular emergency, or steps staff should take in the event of signs and symptoms of a cardiovascular incident. - On [DATE], one day after the resident's death, staff entered the following: - Resident exhibits or is at risk for cardiovascular symptoms or complications related to AFIB and hypertension. Date Initiated: [DATE]. - Observe for chest pain and report abnormalities to physician. Date Initiated: [DATE]. D. On [DATE] at 11:13 AM, during a phone interview, the Corporate Supervisor (CS) stated R #112 had an increased risk for a heart attack due to his cardiovascular history, and staff should have included that information in the resident's care plan when they initially developed it on [DATE]. The CS stated staff added the cardiovascular risk to R #112's care plan after an audit to ensure care plans included the relevant information.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671 Based on interview, and record review, the facility failed to ensure that activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) were maintained for 1 (R #10) of 3 (R #'s 10, 97, and 107) residents sampled for ADLs when staff failed to provide assistance with toileting needs for R #10 when staff told him to use the restroom in his brief instead of assisting him up to the toilet. This deficient practice could likely result in residents' experiencing a decline in their ability to perform activities of daily living (ADLs) and to feel embarrassed and undignified. The findings are: A. Record review of the face sheet for R #10 dated 09/28/24, revealed an initial admitted [DATE] and included the following diagnoses: -Orthopedic aftercare following surgical amputation, -Dehiscence of amputation stump (condition where the wound along the surgical line opens up), -Morbid obesity (severely overweight), -Need for assistance with personal care, -Limitation of activities due to disability, -Acquired absence of right leg above knee, -Seizures (a sudden change in behavior, movement, and/or consciousness due to abnormal electrical activity in the brain), -Primary osteoarthritis (progressively worsening changes in cartilage and joints without a known cause), -Osteoporosis (condition that weakens bones), -Llegal blindness (a level of vision loss that meets specific criteria established by law). B. Record review of the care plan for R #10 dated 08/21/24 revealed the following: -Focus: R #10 required assistance and was dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to diabetes mellitus (DM; high blood sugar) with retinopathy (disease of the eye that causes vision loss/blindness) and neuropathy (nerve damage), legally blind, wheelchair use, amputation (surgical removal of a limb) of right foot, and limited mobility. -Goal: R #10's ADL cares needs will be anticipated and met throughout the next review period. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Provide resident with dependent assist of one to two staff for locomotion using a wheelchair. Provide resident with dependent assist of two staff for transfers using a total lift full body sling and an extra large sling. Provide resident with dependent assist of one to two staff for toileting. Utilize prescribed adaptive equipment wheelchair during mobility activities. C. On 10/23/24 at 2:37 pm during an interview, R #10 stated he did not like being told to have a bowel movement in his brief. He stated there was often not enough staff to help get him up because he needed total staff assistance with the mechanical lift. He stated he prefers to use the toilet and did not want to sit in a soiled brief for long periods of time. He stated that this has happened on several occasions, but could not remember the dates. D. On 10/28/24 at 3:12 pm during an interview, the Director of Nursing stated that it was not an acceptable practice for any staff to tell any resident who was not incontinent to have bowel movements in their brief.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49196 Based on record review and interview, the facility failed to provide quality care to 1 (R #112) of 1 (R #112) residents when they failed to properly assess a resident with history of myocardial infarction (MI; heart attack)) after the resident reported chest pains. If the facility fails to properly assess a resident who reports chest pains, then the resident may experience unidentified life-threatening conditions such as a heart attack. This deficient practice likely contributed to the passing of R #1 within the hour of reporting chest pain. The findings are: A. Record review of R #112's facesheet revealed that R #112 admitted to the facility on [DATE] with the following list of diagnoses (not all-inclusive): -Diabetes mellitus (a chronic disease in that occurs when the body is unable to control blood sugar levels). -Sepsis (a life-threatening extreme immune system response to infection or injury which can cause inflammation, blood clots, and damaged blood vessels reducing the blood flow and oxygen delivered to the body's organs). -Acute respiratory failure (inability to maintain adequate oxygenation in the body). -Atrial fibrillation (AFIB; a type of irregular heartbeat that occurs when the electrical signals in the heart's upper chambers fire quickly and out of rhythm). -Myocardial infarction type 2 (a type of heart attack that occurs when the supply of oxygen to the heart does not meet the heart's demand). -Hypertension (high blood pressure). -Congestive heart failure (a serious long term condition that occurs when the heart cannot pump enough blood to the meet the body's needs). -Full Code (a medical directive that tells a person's health care team to perform all possible life-saving measures if their heart or lungs stop working). B. Record review of R #112's admission Minimum Data Set assessment (MDS; a federally mandated comprehensive assessment of each resident's functional capabilities that helps nursing home staff identify health problems) dated [DATE] revealed staff documented the following for the look back period (The time period over which staff observe a resident to capture the resident's condition or status for the MDS assessment. Unless otherwise stated, the look back period is seven days, and only those occurrences during the look back period will be captured on the MDS.): - Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 14, cognitively intact. -Active diagnoses of atrial fibrillation, heart failure, and hypertension. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-R #112 rated his pain as rare or non-existent -R #112's ability to express ideas and wants was usually understood. Resident had difficulty communicating some words or finishing thoughts but is able if prompted or given time. -R #112 was able to understand others. Resident missed some part/intent of the message but comprehends most conversation. -No behaviors are indicated on the MDS assessment. -R #112's prognosis (life expectancy) was greater than 6 months. C. On [DATE] at 4:20 PM during an interview, CNA #2 stated that on [DATE] she checked on R #112 around 4 PM when he reported to her that his chest was hurting. CNA #2 immediately notified the nurse (LPN #1) who assessed the resident and took vital sign measurements. CNA #2 stated she went to check on R #112 again approximately 45 to 60 minutes later and he was gone (deceased). D. Record review of the National Institutes of Health article titled, Chest Pain, dated [DATE], revealed an assessment for chest pain should include the following components to help rule out serious, life-threatening causes: -Onset: In addition to when the pain started, ask what the patient was doing when the pain started. Was the pain brought on by exertion, or were they at rest? -Location: Can the patient localize the pain with one finger, or is it diffuse? -Duration: How long did the pain last? -Character: Let the patient describe the pain in his or her own words. -Aggravation/alleviating factors: It is very important to find out what makes the pain worse. Is there an exertion component, is it associated with eating or breathing? Is there a positional component? Don't forget to ask about new workout routines, sports, and lifting. Ask what medications they have tried. -Radiation: This may clue you into visceral pain. -Timing: How many times do they experience this pain? For how long does it let up? -Risk factors including: prior myocardial infarction (MI), family history of cardiac disease, smoking, hypertension (HTN), hyperlipidemia (HLD; high cholesterol), and diabetes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	E. Record review of R #112's nursing progress note, dated [DATE] at 4:01 PM and authored by Licensed Practical Nurse (LPN) #1, revealed the Certified Nursing Assistant (CNA) reported the resident complained of chest pain. Staff obtained the resident's vital signs as follows: ,d+[DATE] (blood pressure should be , d+[DATE] or lower); 88 (normal pulse for adults is between 60 and 100); 22 (normal respiratory rate for a resting adult is between 12 and 20); 98.6 (the usual body temperature is generally considered to be between 97 and 99 degrees fahrenheit); on 2.5 liters (L) of oxygen. Staff assessed the resident, and he did not have any complaints at the time. R #112's color was pale, skin was cool, no diaphoresis (sweating). The resident answered questions appropriately. - The record did not contain any other information regarding the resident assessment conducted by LPN #1 or what questions the resident answered appropriately. F. On [DATE] at 2:04 PM and 4:02 PM during an interview, LPN #1 stated the resident was at his baseline when she assessed him. LPN #1 stated she did not ask R #112 about his chest pain (type, duration, frequency), because he was not actively experiencing it. LPN #1 confirmed she did not notify the doctor of R #112's chest pain. She stated she could not recall whether she considered the resident's cardiovascular history when she assessed R #112 on [DATE]. G. On [DATE] at 1:40 PM during an interview, Certified Nurse Practitioner (CNP) #1 stated staff should always take chest pains seriously, because residents may need diagnostics, such as an electrocardiogram (EKG; a test that checks for problems with the electrical activity of the heart) or blood tests to rule out a heart attack. He stated a resident with significant cardiovascular history, such as R #112, was especially at risk and should be sent to the emergency room (ER) if they experienced chest pain in order to be evaluated by a provider. The CNP stated it was expected for staff to notify him if a resident had chest pain, but staff did not notify him of R #112's chest pain. H. On [DATE] at 1:53 PM during an interview, LPN #2 stated residents who experienced any chest pain or other signs of a heart attack or stroke should be sent to out to the ER to determine if a life-threatening condition exists. I. Record review of R #112's nursing progress note, dated [DATE] at 5:00 PM and authored by LPN #1, nursing staff found R #112 in bed without signs of life. Staff initiated cardiopulmonary resuscitation (CPR; an emergency procedure that combines chest compression with artificial ventilation in an effort to manually preserve intact brain function until further measures are taken). EMS (Emergency Medical Service) arrived and took over life-saving efforts which were ultimately unsuccessful. EMS discontinued CPR at 5:34 PM. The family, facility administrator, nursing unit manager, and on-call provider were notified. J. Record review of R #112's nursing progress note, dated [DATE] at 8:02 PM and authored by Registered Nurse (RN) #1, revealed R #112 was pronounced deceased at 7:23 PM on [DATE]. Based on interview and record review, Immediate Jeopardy (IJ) was identified on [DATE] at 11:17 AM to the Administrator and the Director of Nursing, in person. (continued on next page)

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Ladera Center	5901 Ouray Road NW Albuquerque, NM 87120

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The facility took corrective action by providing an acceptable Plan of Removal (POR) on [DATE] at 4:05 PM. Implementation of the POR was verified onsite on [DATE] with ongoing trainings for staff regarding change in condition and assessment of chest pains, and the facility completed a full sweep of all residents was completed to identify any other resident who may be experiencing a change in condition and required provider notification. After verification of POR on [DATE] at 2:11 PM, the scope and severity was reduced to D. Plan of Removal: Identification/Correction: All residents have the potential to be affected by this alleged deficient practice, if the facility fails to monitor and notify the provider of residents for a change in condition related to chest pain. The following identification/corrections will be completed by [DATE]: Licensed nurses will complete head to toe assessments on current residents residing in the center to determine presence of a medical change in condition. Concentration on residents with the potential for cardiac complications (history of MI, CHF, etc) will be assessed for recent history of chest pain or other signs and symptoms of cardiovascular complications. Identified issues will be reported to the provider for further direction and medical orders. Systematic Measures: The Director of Nursing/designee will educate current staff regarding policy for resident change in condition. The education includes: -Change in condition is a sudden, clinically important deviation from a resident's baseline including physical, mental, or psychosocial status. Nursing assessment should have included description of chest pain, severity and how long pain had lasted. In addition, nurse should have considered the resident's heart history when assessing for chest pain. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ladera Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5901 Ouray Road NW Albuquerque, NM 87120	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-All nurses must notify the provider, family and a nurse manager/nurse manager on-call immediately when they identify any change in condition, when the change occurs. If unsure that the residents are having a change, the nurse will consult with the nurse manager or the provider immediately once they have fully assessed the situation and have the information they need. A full head-to-toe assessment needs to be completed by the nurse. The eInteract change in condition documentation needs to be completed specific to the change (ie: chest pain, fall, etc), with the notification noted. The assessment for the eInteract will trigger a specific assessment for chest pain that asks for a description, severity, length of time and if shortness of breath is occurring. This assessment will pull over a resident diagnosis list into the eInteract, change in condition form. It also needs to include all abnormal findings in each system within the form, vital signs, neurological status, chest pain with a history, blood glucose etc. The nurse needs to include a narrative note about what happened before, during and after the event, and the provider orders and interventions that were put into place. Monitoring needs to occur per the change in condition UDA (user defined assessment), and in progress notes as needed, to ensure that if further change occurs, the process is repeated and documented. If the change in condition is an immediate emergency, a nurse should stay with the resident to monitor until EMS arrives. The eInteract UDA, after the initial eInteract change in condition has been completed, triggers continued monitoring of the identified concern. If it is the same concern, continue with the UDA documentation. If it is a different concern, begin another eInteract change in condition assessment. When communicating with the doctor, the nurse must include all information pertinent (including diagnosis pertaining to the change in condition ie: cardiac related diagnosis for chest pain) to the change in condition, and should have it available when calling the doctor. -Nurses will be educated on nurse to nurse shift report that includes resident assessment and any pertinent diagnosis that could put the resident at risk for complications (ie: history of MI). The Director of Nursing/designee will begin education [DATE]. As of [DATE], 100% of currently scheduled staff have been educated on this policy. Any staff member that is not on the current schedule as of [DATE], is on leave of absence (FMLA), vacation, or PRN staff will be educated prior to returning to their next shift. New hires/agency staff will be educated on the above during orientation. Current agency staff are being educated on the above information, and will continue to be educated by the facility human resources and mentor as part of the orientation process, prior to their first shift. The Director of Nursing/designee will review resident progress notes, orders and nursing dashboard during the morning clinical meeting to determine if residents noted change in condition identified, process followed, and monitoring occurred. Quality Assurance and Monitoring The Director of Nursing/designee will audit progress notes 5 days per week in morning clinical meeting to monitor for timely notification of change in conditions. Administrator and/or designee will bring results of audits to QAPI committee for further recommendations based on tracking and trending presented monthly for the next 3 months or until ongoing compliance is achieved. The QAPI committee is overseen by the Administrator.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on interviews and record review, the facility failed to follow dietary orders regarding food allergies for 1 (R # 77) of 1 (R #77) resident reviewed with food allergies. This failure had the potential to affect residents with food allergies. This deficient practice could likely cause a resident to have a medical emergency due to food allergies. The findings are. A. On 10/22/24 at 10:00 am, during an interview with R #77, she stated she had received a strawberry banana yogurt today (10/22/24) and another time she received strawberry banana yogurt. On 10/02/24, R #77 stated that she got an actual banana with her meal. R #77 stated she is worried that she could be in danger as she has a banana allergy, even if it is banana-flavored. R #77 stated the allergy is documented on her meal ticket. Although she avoids eating bananas, she finds it strange that she still experiences allergic reactions to food containing banana flavor. She confirmed that she has photographic evidence from the three days she received both the banana and the strawberry banana yogurt. B. Record review of R #77's facesheet, dated 10/01/24 revealed the resident was admitted on [DATE]. Further record review revealed R #77's allergies were erythromycin (antibiotic), Keflex (antibiotic), and bananas C. Record review of R #77's diet order, dated 01/02/23, revealed a nutritional concern for a banana allergy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40671 Based on interview and observation the facility failed to ensure staff served meals that were attractive and palatable (pleasant to taste) for 3 (R #'s 10 , 52, and 54) of 5 (R #'s 10, 52, 54, 97 and 107) residents reviewed for meal quality. This deficient practice reduces residents' ability to eat and enjoy meals, may decrease their quality of life, and could likely lose weight. The findings are: R #10A. On 10/22/24 at 3:31 pm, during an interview, R #10's Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care) stated she witnessed on numerous occasions while visiting with R #10, staff delivered the resident's food being last and cold. She stated R #10 often did not eat because the food was unrecognizable and tasted horrible. B. On 10/23/24 at 2:40 pm, during an interview, R #10 stated his meals were often cold by the time staff served him. He stated staff forget to deliver his meals to his room on several occasions. He stated he ate all his meals in his room. R #52 C. On 10/23/24 at 10:04 am during an interview, R #52 stated that the facility food was not good tasted bad and was the wrong temperature approximately 50 percent (%) of the time. R #54 D. On 10/21/24 at 11:06 am during an interview, R #54 stated staff always served the food late and cold. E. On 10/28/24 at 1:12 pm during an observation, staff had not yet served the lunch meal to resident #54. Lunch Meal Observations F. On 10/21/24 during a random observation of lunch meal service, in the dining room, staff began to serve beverages to the residents at 12:46 pm. Further observation revealed staff served the first meal tray at 12:56 pm. G. On 10/24/24 during a random observation of lunch meal service in the dining room, revealed staff began to serve beverages to the residents at 12:49 pm, and staff served the first meal tray at 1:02 pm. Further observations revealed staff served the last meal tray in the dining room at 1:17 pm, and staff had not yet delivered the room meal cart to the halls at 1:20 pm. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. On 10/25/24 at 1:26 pm during an observation of a test tray revealed that the presentation of the meal plate was unappealing and colorless; it consisted of a hamburger a small bowl of baked beans on a white plate. The test tray also included a small bowl of chopped lettuce and tomatoes, a four ounce container of melting orange fat free sherbet, two packets of ketchup, and one packet of yellow mustard. There was not a beverage provided with sample tray. A taste test revealed the hamburger was flavorless, the meat was unseasoned, and there was not any salt or pepper provided. I. On 10/25/24 during an observation of room tray meal delivery revealed staff served the last resident room meal was served at 1:32 pm. J. Record review of posted meal time for lunch service was 12:30 pm. K. On 10/28/24 at 2:22 pm during an interview, the Dietary Manager stated he initially received a lot of complaints that the food did not taste good and was served cold, when he began his employment about two months ago. He stated dietary staff are expected to have lunch ready to serve in the dining room at 12:30 pm, and the the hall trays by 12:45 pm. The DM stated meals were often arriving late when the kitchen was short staffed, but that is has improved now that they were fully staffed. 49196

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40671 Based on observation and interview, the facility failed to serve food under sanitary conditions when staff did not use proper handling techniques of glasses, bowls, and drinks while distributing meals to residents in the dining room. This deficient practice is likely to affect all 117 residents listed on the resident census list provided by the administrator on 10/21/24; and could likely lead to foodborne illnesses in residents if safe food handling practices are not adhered to. The findings are: A. On 10/21/24 at 12:56 pm during an observation of the lunch meal service revealed an activity staff member assisted with meal service to the residents. The activity staff handled the resident's cups and and bowls by the rims. He did not perform hand hygiene between serving the resident trays. Observation revealed that these residents consumed these food and beverages. B. On 10/21/24 at 12:59 pm, an observation of the lunch meal service revealed an unknown female staff member assisted with meal service to the residents. The unknown staff handled resident bowls of food with her thumb touching the inside rim of the bowl. Observation revealed that these residents consumed these food and beverages. C. On 10/24/24 at 12:49 pm, an observation of the lunch meal service revealed Certified Nursing Aide (CNA) #1 handled a bowl of vegetables, with her thumb inside the bowl, and delivered the bowl to a resident. CNA #1 handled a glass of juice and a bowl of vegetables by the rims, and she delivered the items to another resident. The CNA continued to handle bowls by the rim, with her thumb on the inside of the bowl, as she delivered a meal to another resident. D. On 10/28/24 at 2:22 pm during an interview, the Dietary Manager stated his expectation was for dietary staff to follow proper handling and serving practices. He stated it was expected for all staff who assisted with serving to follow proper handling and serving practices.