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	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and interviews, the facility failed to maintain a safe, clean, and sanitary environment by allowing fecal matter to remain on the floor of a common resident area and by failing to ensure proper separation between soiled laundry and clean linens. These deficient practices has the potential to affect residents, staff, and visitors by increasing the risk of healthcare-associated infections.The findings are:A. On 01/26/26 at 2:01 pm during an observation of the south shower room, brown fecal matter was on the floor, the shower chair, and the shower curtain. A pungent (strong, unpleasant smell), offensive odor was immediately detectable upon entering the space.B. On 01/26/26 at 2:02 pm during an interview with the environmental services regional manager (EVSR), she confirmed that the brown fecal matter was found on the shower chair, shower floor and shower curtain. EVSR stated that this is unsanitary and should have been addressed as soon as a staff is done helping a resident using the shower room and it did not happen.C. On 01/26/26 at 2:12 pm during an observation of the north shower room, a used facility gown was noted next to an uncovered clean towel rack.D. On 01/26/26 at 2:13 pm during an interview with the EVSR, she confirmed that the used facility gown should have been placed in the soiled clothing container as soon as possible to prevent cross contamination. She also confirmed that the clean towel rack should have been covered and it did not happen.

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 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. Based on record review and interview, the facility failed to make prompt (done without delay; immediate) efforts to resolve resident's grievances for 10 (R #'s 4, 6, 8, 39, 41, 48, 56, 72, 74 and 107) of 10 (R #'s 4, 6, 8, 39, 41, 48, 56, 72, 74 and 107) residents reviewed by:1.Not responding/following-up to grievances that involved missing personal items and smoking.2.Not responding to grievances that involved allegations of neglect for several days after the grievance was reported. 3. Failing to educate all nursing staff, including the nursing staff involved, for grievances with allegations of neglect. If the facility is not ensuring that grievances are responded to 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: A. On 01/21/26 at 12:35 PM during a telephone interview with R #41's family member, he stated that he had brought his aunt a TV on 04/07/24 and it was taken from her room, he further stated that he had contacted the facility to let them know that the TV was gone, and he has not gotten a response from the facility as of this date (01/21/26).B. On 01/22/26 at 12:12 pm during an interview with the Social Service Assistant (SSA), she stated she had gotten an email but did not recall the date from R #41's nephew that R #41's TV was missing and she had not written a grievance report and she did not follow-up on what had happened with R #41'a TV and she should have.C. On 01/22/26 at 12:54 PM during an interview with Maintenance Director (MD) he stated R #41's family had purchased a TV for her (R #41's) the facility was unable to connect it to the cable available in the room. The MD removed the TV from the room and replaced it with a facility TV on 10/23/24 and left R #41's TV in the R #41's room and it disappeared and he does not know where it went. MD confirmed R #41's TV is missing and he confirmed he did not notify the family that the TV was missing. MD stated that he should have followed -up with the family and let them know that the TV had been replaced with a facility purchased TV.D. On 01/21/26 through 01/22/26 during interview withs R #'s 4, 6, 8,39,48, 56, 72,74 and 107 they all stated that they had missing personal clothing and had filed grievances on the missing items and the items have not been found nor have they been replaced. All nine residents stated they have not gotten a response after filing a grievance report and they would like to know if their items will be replaced.E. On 01/22/26 at 11:35 am during an interview with the Social Services Director (SSD) she stated that follow-up with any grievance should be seven days to gather information if they are unable to be found then it could be communicated to the Administrator. F. Record review of facility's grievances dated 01/07/26 through 01/08/26 revealed that missing person item grievances had not been acted upon. G. On 01/22/26 at 1:37 pm during an interview with the facility Administrator, he stated, that the reason there was no response on the grievance form is because they have not been resolved and the facility is still looking for the missing items. H. On 01/28/26 at 10:00 am during an interview with Laundry Director, she stated that she has not responded to about two months of grievances because her department is short staffed and has not had the time to go through the grievances. I. On 01/22/26 at 11:00 am during an interview with residents at the resident council meeting R #79 stated that they would like more smoke breaks, she further stated that the Administrator had stated there was no one to watch the residents outside while smoking. She stated that previous to the present Administrator the residents allowed the residents six smoke breaks during the day and current Administrator had cut it down to three smoke breaks a day and had not talked to the residents about making those changes and she thought it should have been brought to resident council to discuss. R #79 also stated that Administrator had discussed with her about being a volunteer to watch the smokers during break and she was willing to do that. Administrator had to give her a test to confirm she was a safe smoker and capable of watching other residents during smoke breaks. He also was going to purchase a walkie talkie (form of communication with staff) set so she would be able to communicate with facility staff should any (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	issues arise. R #79 stated that it has been several months since that conversation and the Administrator had not contacted her again about being the volunteer. R #79 stated issues of smoking have been brought up several times and has not gotten a response. J. Record review of current facility smoking times reveals 9:00 am, 2:00 pm and 7:30 pm.K. Record review ow Resident council minutes dated 10/21/26 revealed, Smoking is allowed only during smoking times. L. On 01/27/26 at 1:42 pm during an interview with the facility Administrator, he stated that he had changed the smoking times and the frequency. He further stated that he had spoken to R #79 about being the volunteer and she had declined. He stated residents that are evaluated as safe smokers are allowed to sign themselves out of the facility can go to the sidewalk in front of the facility to smoke. Administrator further stated that he did not document when he spoke to the resident council nor when he spoke to R #79 about taking the test to become a volunteer. M. Record review of the facility's grievance form dated 01/06/26 revealed R #107 's family member had voiced a concern during a care conference (meeting to discuss residents care), family member voiced that her sister R #107 had stated to her that on Monday, January 5th, 2026 she had been put to bet between 2:00 and 3:00 pm and the Certified Nurse Aide (CNA) that put her to bed expressed to her that she would help her change into night clothes by never came back to change her. and she had had to sleep in her clothing and her shoes on the entire night .N. On 01/22/26 at 12:12 pm during an interview with the Social Services Assistant (SSA) she stated that she had written the grievance during the care conference and had handed it to nursing and did not feel that she had to follow up with nursing about the response of the grievance. SSA further stated that she was not aware that there was no follow-up with the family either. SSA stated she should have followed up on the grievance since she is the one that wrote the grievance for the family.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide the required transfer information to the residents' and the residents' representatives in writing for 2 (R #118, and 131) of 2 (R #118, and 131) residents sampled for hospitalizations when staff failed to: 1. Notify the residents and resident representative(s) of the resident's transfer to the hospital in writing and in a language and manner they understand. 2. Send a written copy of the Transfer Notice to the Ombudsman (is a government official who investigates and tries to resolve complaints). 3. Ensure resident or their representative received a written notice of the bed hold policy which indicated the duration the bed would be held. These deficient practices could likely result in the residents and/or their representative not knowing the reason for the transfer, the location of the transfer or discharge, their rights to advocate and make informed decisions regarding the residents' healthcare. The findings are: R #118 A. Record review of the facility's Transfer and Discharge policy, dated 06/11/25, revealed the facility must ensure documentation is complete, involve the physician in the decision, notify the residents and/or their representative, issue a written notice, and assist with safe and appropriate discharge planning. The policy also stated residents must be informed of their right to appeal, and staff must notify the Ombudsman. B. Record review of R #118's admission record revealed he was admitted to the facility on [DATE]. C. Record of R #118's progress note dated 09/06/25 revealed resident was sent to the hospital due to abnormal other lab value or study,resident on cancer medication treatment, peg tube feeding, (is the use of a percutaneous endoscopic gastrostomy (PEG) tube to provide nutrition directly to the stomach for individuals who cannot eat or drink enough by mouth the use of a percutaneous endoscopic gastrostomy (PEG) tube to provide nutrition directly to the stomach for individuals who cannot eat or drink enough by mouth) bed bound, and tested positive for COVID. D. Record review of R #118's medical record, no date revealed staff did not document a transfer notice or a bed hold notification for R #118's transfer to the hospital on [DATE]. E. On 01/22/2026 at 10:00 AM, during an interview, the Social Service Director (SSD) stated R #118 was sent to the hospital due to a positive COVID test, his blood count was low and he was declining rapidly. SSD stated there are no notes in R #118's record of why R #118 did not return to the facility. SSD stated she didn't contact the ombudsman to inform the ombudsman when R #118 was discharged from the facility. SSD stated she does not see any nurses' notes regarding resident's transfer, discharge, and bed hold notice. R #131 F. Record review of R #131's face sheet revealed he was admitted to the facility on [DATE]. G. Record of R #131's progress note dated 01/12/26 revealed resident was sent to the hospital due to behavioral symptoms (agitation, psychosis). H. Record review of R #131's medical record, no date revealed staff did not document a transfer notice or a bed hold notification for R #131's transfer to the hospital on [DATE]. I. On 01/22/2026 at 10:03 AM, during an interview with SSD, she stated R #131 was discharged to the hospital due to his behavior. The psychiatric physician from the hospital informed the facility he was not safe to return to the facility and wrote an order to send resident to a psychiatric hospital. SSD stated she does notify the ombudsman of discharges; however, she has not notified ombudsman in a while. SSD stated she does not see any nurses' notes regarding resident's transfer, discharge, and bed hold notice. J. On 01/22/26 at 4:40 PM, during an interview with the Director of Nursing (DON) stated she did not realize that nursing was to do the transfer and bed hold notice process. DON's expectation is that the nurses and the business office send out the transfer, discharge, and bed hold notices within 24 hours.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 3 (R #39, #47, and #122) of 3 (R #39, #47, and #122) residents reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are: R #39:A. Record review of R #39's facesheet revealed he was admitted on [DATE] with the following diagnoses (including but not limited to): 1. Nondisplaced fracture (nondisplaced fractures are often closed and do not move out of alignment) of right ulna (longer of the two bones in the forearm) styloid process (a slender projection of bone at the lower end of the ulna), subsequent encounter for closed fracture with routine healing. 2. Muscle weakness (generalized) 3. Other abnormalities (deviation from the normal) of gait (walking) and mobilityB. Record review of R #39's electronic health record revealed R #39's baseline care plan dated 12/27/25 did not include: 1. Use of right wrist brace 2. Use of oxygen C. On 01/21/26 at 1:58 pm during an interview with the Director of Nursing (DON), she confirmed R #39's baseline care plan was dated 12/27/25. The DON also confirmed that the baseline care plan omitted required information, such as use of wrist brace and oxygen use.R #47:D. Record review of R #47's facesheet revealed he was admitted on [DATE] with the following diagnoses (including but not limited to): 1. Chronic idiopathic constipation (is a condition with constipation symptoms but no identifiable cause). 2. Personal history of other diseases of the digestive system. 3. Cerebral Palsy (a neurological condition that affects muscle movement and development due to brain damage).E. Record review of R #47's physician's order revealed an order dated 01/10/26 for Lactulose oral solution 10 (grams) gm / 15 (milliliters) ml, give 30 ml by mouth one time a day for constipation. F. Record review of R #47's care plan dated 01/20/26 revealed the following: 1. R #47 requires assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: cerebral palsy. 2. R #47 is at risk for falls due to impaired mobility. 3. R #47 exhibits or is at risk for alterations in comfort related to chronic pain. 4. R #47 is at risk for skin breakdown related to decreased activity. 5. Chronic idiopathic constipation is not addressed in this care plan.G. On 01/22/26 at 3:15 pm during an interview with the Unit Manager (UM), she confirmed that R #47's care plan does not meet her expectations because it does not include R #47's chronic idiopathic constipation or the care and support he needs.R #122H. Record review of R #122's facesheet revealed she was admitted on [DATE] with the following diagnoses (including but not limited to): 1. Displaced intertrochanteric (a fracture type of broken hip) fracture of left femur (the bone of the thigh). 2. Displaced comminuted (reduced to minute particles or fragments) fracture of shaft of radius (one of the bones in the forearm), left arm. 3. Difficulty walking. 4. Age-related osteoporosis (bones to become weak and brittle).I. Record review of R #122's care plan dated 01/02/26 revealed the following: 1. R #122 requires assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to recent fall, left femur and left wrist fracture. 2. R #122 has a diagnosis of diabetes. 3. R #122 has potential for discharge or is expected to be discharged home. 4. R #122 is at risk for falls. 5. R #122 exhibits or is at risk for alterations in comfort related to fracture of left femur, and left wrist. 6. R #122 is at risk for complications related to the use of psychotropic drugs. 7. R #122 is at risk for skin breakdown related to decreased activity, incontinence, and limited mobility. 8. Wound care is not addressed in this baseline care plan.J. On 01/27/26 at 1:13 pm during an interview with the UM, she confirmed that R #122 arrived at the facility with a surgical wound related to hip surgery. She also (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confirmed that R #122's care plan did not address wound care related to hip surgery. The UM expects the wound care to the right hip should be added to the baseline care plan on admission and it did not happen.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 3 (R #41, R #47 and R #122) of 8 (R #11, R #12, R #41, R #47, R #48, #118, R#122 and R #131) residents reviewed when staff failed to: 1. Revise the care plan after R #41 developed hand contractures.ˆ 2. Revise the care plan after R #47 was diagnosed with chronic idiopathic constipation (condition with constipation symptoms but no identifiable cause). 3. Ensure the required Interdisciplinary Team (IDT, team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) members participated in the care plan meeting for R #122. These deficient practices could result in residents' care and needs not being addressed.ˆ The findings are: R #41 A. Record review of R #41's facesheet revealed she was admitted on [DATE] with the following diagnoses (including but not limited to): 1. Hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (also known as ischemic stroke, occurs when the blood supply to part of the brain is blocked or reduced) affecting right dominant side.** 2. Aphasia (is a language disorder that affects your ability to speak and understand what others say) following cerebral infarction.** 3. Dysphagia (difficulty swallowing) following cerebral infarction.** B. Record review of R #41's care plan, last updated on 12/29/25 revealed the care plan did not contain any goals or interventions in place for R #41's bilateral hand contractures and support she needs. C. On 01/22/26 at 3:15 pm during an interview with the Unit Manager (UM), she confirmed R #41's care plan does not meet her expectations because it does not include her bilateral hand contractures or the care and support she needs. R #47D. Record review of R #47's facesheet revealed he was admitted on [DATE] with the following diagnoses (including but not limited to): 1. Chronic idiopathic constipation. 2. Personal history of other diseases of the digestive system. 3. Cerebral Palsy (a neurological condition that affects muscle movement and development due to brain damage). E. Record review of E #47's physician's order revealed: 1. 01/10/26: Lactulose oral solution 10 (grams) gm / 15 (milliliters) ml, give 30 ml by mouth one time a day for constipation. F. Record review of R #47's care plan dated 01/20/26 and revealed the following: 1. R #47 requires assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: cerebral palsy. 2. R #47 is at risk for falls due to impaired mobility. 3. R #47 exhibits or is at risk for alterations in comfort related to chronic pain. 4. R #47 is at risk for skin breakdown related to decreased activity. 5. Chronic idiopathic constipation is not addressed in this care plan. G. On 01/22/26 at 3:15 pm during an interview with the Unit Manager (UM), she confirmed that R #47's care plan does not meet her expectations because it does not include R #47's chronic idiopathic (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	constipation or the care and support he needs. H. Record review of R #122's Care Plan Conference form, dated 01/05/26, revealed the following: 1. Staff documented the individuals that were present at the meeting were R #122's representative, Nurse, Rehab, R #122 and the Social Services Director (SSD). 2. Staff that were not documented to be in attendance were R #122's certified nurse aide (CNA), and physician. I. On 01/22/26 at 09:47 AM, during an interview, the SSD stated that for care plan meeting dates for R #122 occurred on 01/05/26 and 01/13/26. SSD state R #122 and her family members (FM) were in attendance. The Interdisciplinary Team (IDT) present including rehab, nurse, and director of social services. SSD stated the provider and the CNA are not included in the IDT meetings. SSD stated she didn't know that CNA, and the provider had to be in attendance.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to provide quality care that meets professional standards for 6 (R #5, #39, #56, #90, #93, and #104) of 6 (R #5, #39, #56, #90, #93, and #104) residents reviewed when the staff failed to:-Follow physician orders.-Obtain physician ordersThese deficient practices are likely to result in residents not maintaining their optimal health as planned by their medical provider. The findings are: R #39: A. Record review of R #39's facesheet revealed he was admitted on [DATE] with the following diagnoses (including but not limited to): ˆ1. Nondisplaced fracture (nondisplaced fractures are often closed and do not move out of alignment) of right ulna (longer of the two bones in the forearm) styloid process (a slender projection of bone at the lower end of the ulna), subsequent encounter for closed fracture with routine healing. 2. Muscle weakness (generalized) 3. Other abnormalities of gait (is the pattern or manner of walking) and mobility 4. Influenza A virus with other respiratory manifestations (a respiratory illness). B. On 01/21/26 at 09:52 am during an observation inside R #39's room, R #39 was sitting on his wheelchair with his daughter at his side. R #39 had a brace to his right wrist and is receiving oxygen therapy via nasal cannula at 2 liters per minute (LPM). C. On 01/21/26 at 09:53 am during an interview with R #39, he stated his right wrist brace came from the hospital after he fell from home. R #39 stated he fell and broke his right wrist but does not require surgery. R #39 also stated that he does know why he is receiving oxygen at this facility. D. Record review of R #39's physician's order revealed R #39's does not have an order for oxygen therapy and right wrist brace. E. On 01/21/26 at 10:03 am during an interview with the Director of Nursing (DON), she confirmed R #39 has a right wrist brace and is receiving oxygen therapy with no orders in the electronic medical records. The DON stated that this should have been addressed by the nurses and received an order from the providers, but it did not happen. R #56 F. Record review of R #56's facesheet revealed she was admitted on [DATE] with the following diagnoses (including but not limited to): ˆ ˆ 1. Type 2 diabetes mellitus (the body [NAME] use insulin correctly and sugar builds up in the blood) with hyperglycemia (happens when there's too much sugar in the blood). ˆ ˆ 2. Body mass index (BMI) 60.0 to 69.9, adult. ˆ ˆ 3. Long term use of insulin (natural hormone that turns food into energy and manages blood sugar level). ˆ ˆ 4. Long term use of injectable non-insulin antidiabetic drugs. G. Record review of R #56's physician's order revealed the following: ˆ ˆ 1. 08/13/24: Mounjaro (prescription once weekly injectable medication for type 2 diabetes) pen-injector 2.5 MG (milligrams) / (per) 0.5 (milliliters) ML, inject 0.5 ml subcutaneously (applied under the skin) every Wednesday. Discontinued 08/14/25. ˆ ˆ 2. 08/14/24: Mounjaro pen-injector 2.5 MG / 0.5 ML inject 0.5 ml (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	subcutaneously one time a day every Wednesday. Discontinued 01/29/25. ^ ^ 3. 01/29/25: Mounjaro auto-injector 2.5 MG / 0.5 ML inject 0.5 ml subcutaneously at bedtime every Thursday. Discontinued 04/22/25. ^ ^ 4. 04/22/25: Mounjaro auto-injector 5 MG / 0.5 ML inject 0.5 ml subcutaneously at bedtime every Thursday. Discontinued 05/07/25. ^ ^ 5. 05/07/25: Mounjaro auto-injector 2.5 MG / 0.5 ML inject 2.5 mg subcutaneously one time a day every Thursday. Discontinued 07/09/25. ^ ^ 6. 07/09/25: Mounjaro auto-injector 5 MG / 0.5 ML inject 0.5 ml subcutaneously at bedtime every Thursday. Discontinued 08/01/25. ^ ^ 7. 08/01/25: Mounjaro auto-injector 5 MG / 0.5 ML inject 0.5 ml subcutaneously at bedtime every Saturday. Discontinued 08/04/25. ^ ^ 8. 08/04/25: Mounjaro auto-injector 5 MG / 0.5 ML inject 0.5 ml subcutaneously at bedtime every Thursday. Discontinued 09/19/25. ^ ^ 9. 09/19/25: Mounjaro auto-injector 5 MG / 0.5 ML inject 0.5 ml subcutaneously one time a day every Thursday. Discontinued 10/03/25. ^ ^ 10. 10/03/25: Mounjaro auto-injector 5 MG / 0.5ML inject 0.5 ml subcutaneously one time a day every Thursday. (current active order) H. Record review of R #56's medication administration record (MAR) revealed R #56 missed her mounjaro injectable medications on 04/17/25, 07/31/25, and 08/21/25. I. On 01/26/26 at 9:31 am during an interview with R #56, she stated the facility is not consistently giving her mounjaro medications. R #56 stated she is to receive the injection once a week, some weeks the medication is not available, and we just skip that dose.^ J. On 01/26/25 at 09:50 am during an interview with the Assistant Director of Nursing (ADON), she stated they were having a hard time getting medications from the pharmacy due to insurance pre-authorization. ADON confirmed R #56's missed her mounjaro injectable medications; The medication was not available on 04/17/25, and 08/21/25 doses, and for the 07/31/25 dose, the medication arrived on 08/04/25 and R #56 refused the medication because it was too close to her next dose. The ADON also stated that the nurses should be able to request the medication from the pharmacy as soon as they found out it was not available and it did not happen. ^ R #90 K. Record review of R #90's facesheet revealed she was admitted on [DATE] with the following diagnoses (including but not limited to): ^ ^ 1. Hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following unspecified cerebrovascular disease (various medical conditions that impact the blood vessels in the brain) affecting right dominant side. ^ ^ 2. Vascular dementia (a type of cognitive impairment cause by reduced blood flow to the brain, leading to memory loss, confusion and changes in behavior), unspecified severity, with other behavioral disturbance ^ ^ 3. Aphasia (disorder that affects language abilities due to brain damage) following cerebral infarction. ^ ^ 4. Dysphagia (difficulty swallowing) following cerebral infarction. L. Record review of R #90's physician's order revealed a dietary order dated 01/08/25 for a scoop plate (a specialized plate designed to assist individuals who have difficulty using regular plates) and sippy cup for hot beverages. M. On 01/27/26 at 12:35 pm during an observation in the dining room, R #90 was served hot coffee in a regular cup. Further observation revealed the dietary meal slip indicated sippy cup for hot beverages. N. On 01/27/26 at 12:36 pm during an interview with admission's coordinator (AC), she confirmed the hot coffee was served in a regular cup. AC stated that per R #90's dietary order all hot beverages (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be served in a sippy cup and it did not happen. R #5: O. Record review of R #5's face sheet revealed he was admitted on [DATE] with the following diagnoses (including but not limited to): -Multiple Sclerosis (is a chronic neurological disorder), Unspecified. -Type 2 Diabetes Mellitus without complications. -Muscle Weakness (Generalized) -Unspecified rotator cuff tear or rupture (is a common cause of shoulder pain and disability among adults) of right shoulder, no specified at traumatic. P. Record review of R #5's care plan dated 07/03/25, revealed Built -Up-Utensils for all meals. Q. Record review of R #5's physician's order did not reveal an order for Built-Up-Utensils.^ R. On 1/26/26 at 12:34 pm, during an interview with Occupational Therapist (OT), he stated he does an evaluation for built-up-utensils and will notify dietitian and dietary and they will put it on the computer for their meal tickets. He further stated, ultimately if a resident needs built-up-utensils for a long period of time a physician's order is needed for it. R #93: S. Record review of R #93's face sheet revealed he was admitted on [DATE] with the following diagnoses (including but not limited to): -Alzheimer's Disease (is the most common form of dementia, a brain disorder that slowly destroys a person's memory and thinking skills) with late onset. -Vascular Dementia (is a type of dementia caused by reduced or blocked blood flow to the brain, leading to brain cell damage and cognitive decline), Unspecified severity, without behavioral disturbance, mood disturbance, and anxiety (mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). -Psychophysiologic Insomnia (is a chronic sleep disorder where heightened mental, emotional, or physical arousal and learned sleep-preventing associations make it difficult to fall or stay asleep). -Unspecified hearing loss (is the partial or complete inability to hear sounds in one or both ears, which can significantly impact communication and quality of life), unspecified ear. T. Record review of R #93's care plan dated 11/19/25, revealed rehab eating devices, scoop plate during meals. U. Record review of R #93's physician's order dated 03/20/23 did not reveal an order for scoop plate during meals.^ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. On 1/26/26 at 12:34 pm, during an interview with Occupational Therapist (OT), he stated he does an evaluation for built-up-utensils and will notify dietitian and dietary and they will put it on the computer for their meal tickets. He further stated, ultimately if a resident needs built-up-utensils for a long period of time a physician's order is needed for it. R #104: W. Record review of R #104's face sheet revealed he was admitted on [DATE] with the following diagnoses (including but not limited to): -Contracture (abnormal shortening of muscle tissue, rendering the muscle highly resistant to stretching), left hand. -Orthostatic Hypotension (blood pressure fall when standing from the supine [lying flat] to the erect [upright] position). -Restless Legs syndrome (is a condition that causes a very strong urge to move the legs). -Presence of Neurostimulator (An implantable neurostimulator is a surgically placed device about the size of a stopwatch. It delivers mild electrical signals to the epidural space near your spine through one or more thin wires, called leads). X. Record review of R #104's care plan dated 02/24/24, revealed Built -Up-Utensils for all meals. Y. Record review of R #104's physician's order did not reveal an order for Built-Up-Utensils.ˆ Z. On 1/26/26 at 12:34 pm, during an interview with Occupational Therapist (OT), he stated he does an evaluation for built-up-utensils and will notify dietitian and dietary and they will put it on the computer for their meal tickets. He further stated, ultimately if a resident needs built-up-utensils for a long period of time a physician's order is needed for it.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews, the facility failed to ensure that activities of daily living (ADL) are being provided to 2 (R #39, and #41) of 2 (R #39, and #41) residents reviewed, who were dependent on staff for necessary nail care. This deficient practice resulted in residents having long, jagged, and unclean fingernails, which poses a risk for the transmission of infection.The findings are:R #39A. Record review of R #39's facesheet revealed he was admitted on [DATE] with the following diagnoses (including but not limited to): 1. Nondisplaced fracture (nondisplaced fractures are often closed and do not move out of alignment) of right ulna (longer of the two bones in the forearm) styloid process (a slender projection of bone at the lower end of the ulna), subsequent encounter for closed fracture with routine healing. 2. Muscle weakness (generalized). 3. Other abnormalities of gait (is the pattern or manner of walking) and mobility.B. On 01/21/26 at 9:52 am, during an observation of R #39's room with his daughter, R #39's fingernails on both hands were long, and contained a dark, brown substance underneath the nail beds. R #39 stated no one has addressed his fingernails since his admission to this facility.C. On 01/21/26 at 10:01 am during an interview with Certified Nursing Aide (CNA) #1, she confirmed R #39's fingernails are long and dirty. CNA #1 stated that nail care is done regularly but it did not happen.R #41D. Record review of R #41's facesheet revealed she was admitted on [DATE] with the following diagnoses (including but not limited to): 1. Hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (also known as ischemic stroke, occurs when the blood supply to part of the brain is blocked or reduced) affecting right dominant side. 2. Aphasia (is a language disorder that affects your ability to speak and understand what others say) following cerebral infarction. 3. Dysphagia (difficulty swallowing) following cerebral infarction.E. The following observations revealed: 1. On 01/20/26 at 1:30pm, R #41 appeared to be sleeping in bed, R #41's fingernails on both hands were long, and contained a dark, brown substance underneath the nail beds. 2. On 01/21/26 at 2:58pm, R #41's fingernails on both hands were long, and contained a dark, brown substance underneath the nail beds. 3. On 01/22/26 at 2:57pm, R #41's fingernails on both hands were long, and contained a dark, brown substance underneath the nail beds.F. The following interviews revealed the following: 1. On 01/20/26 at 1:32pm interview with CNA #1, she confirmed that R #41's fingernails are long and dirty. CNA #1 stated that nail care is done regularly but it did not happen. 2. On 01/21/26 at 2:59pm interview with CNA #2, she confirmed that R #41's fingernails are long and dirty. CNA #2 stated that R #41 received a shower yesterday and R #41's fingernails should have been addressed, and it did not happen. 3. On 01/22/26 at 2:58pm interview with Certified Medication Aide (CMA) #1, she confirmed that R #41's fingernails are still long and dirty. 4. On 01/22/26 at 3:15pm interview with the Unit Manager (UM), she stated that CNAs are expected to provide nail care during shower days (and as needed) and it did not happen.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and interviews, the facility failed to properly store medications and medical supplies located in the facility medication carts and medication storage room when the staff failed to ensure:-Treatment carts are not left unlocked and unattended.-Medical supplies are not opened or used.-An expired insulin (a hormone that regulates the amount of glucose in the blood) pen was properly discarded.These deficient practices are likely to result in medications and medical supplies being used in resident care resulting in residents being at risk of possible infections, and medication error.The findings are:A. On [DATE] at 8:06 am, during an observation of the south station, a treatment cart with prescription topical ointments, powders, and wound cleaning supplies was left unlocked and unattended.B. On [DATE] at 8:08 am during an interview with the Director of Nursing (DON), she confirmed the south station treatment cart was left unlocked and unattended. The DON stated that all treatment carts are expected to be locked and did not happen.C. On [DATE] at 08:09 am, during an observation of the north station treatment cart, two opened suture removal kit (pre-packaged collections of tools designed for the safe and efficient removal of sutures once a wound has healed) was found on the top drawer. D. On [DATE] at 8:10 am during an interview with Licensed Practical Nurse (LPN) #3, she confirmed that the two suture removal kits were open and left on the top drawer. LPN #3 stated that any medical supplies should be discarded appropriately and it did not happen.E. On [DATE] at 8:12 am, during an observation of the south front medication cart, an insulin pen with a discard date of [DATE] was found. F. On [DATE] at 8:14 am during an interview with LPN #4, she confirmed that the insulin pen was dated [DATE]. LPN #4 stated the insulin pen is considered expired and should be discarded appropriately and it did not happen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, and interviews, the facility failed to implement and follow an ongoing infection prevention and control program (a program that is used to prevent, recognize, and control the onset and spread of infections) by ensuring: -staff follow the established hand hygiene protocols to prevent the potential spread of infection residents observed during meal assistance. -a system of surveillance is in placed to identify environmental hazards before they could spread to residents and staff.These deficient practices are places the residents and staff at risk of contracting infections. The findings are:A. On 01/27/26 at 12:40 pm, during an observation in the dining room, Certified Nursing Aide (CNA) #3 assisted R #20 and R #42 with their meals. The residents were seated at the same table, CNA #3 performed the following sequence of actions: 1. CNA #3 used her bare right hand, touched R #20's spoon, scooped a spoon full of food and placed the same spoon in R #20's right hand. CNA #3 instruction R #20 to place the spoon in her mouth and eat. 2. Without performing hand hygiene, CNA #3 then turned to R #42, picked up R #42's spoon with her bare hands, scooped a spoon full of food, and then placed the spoon in R #42's hand and instructed R #42 to eat. 3. CNA #3 then returned to R #20 and continued assisting without any hand hygiene interventions.B. On 01/27/26 at 12:46 pm interview with the Director of Nursing (DON) confirmed that CNA #3 did not perform hand hygiene between helping residents during this meal time. The DON stated that hand hygiene should be performed between resident care and it did not happen.C. Refer to F0584 for related findings.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations and interviews, the facility failed to ensure that the resident call system was accessible for 2 (R #8, and #41) of 2 (R #8, and #41) residents reviewed. This deficient practice had the potential of placing the resident at risk for inability to summon health care workers as needed to receive assistance that may include urgent care to meet their medical, physical, mental, and psychosocial needs.The findings are:A. On 01/20/26 at 4:18 pm, during an observation, R #8 was found in bed with her call light button on the side of the bed nearly touching the floor. R #8 stated that she uses her call light button to call for help, but she does not know where her call light button went.B. On 01/20/26 at 4:20 pm interview with Licensed Practical Nurse #1, she confirmed the call light button is on the side of the bed and is not within reach of R #8. LPN #1 stated that call light buttons must be within reach at all times and it did not happen.C. On 01/21/26 at 9:44 am, during an observation, R #41 was found in bed with her call light button draped over the headboard and is not within reach. D. On 01/21/26 at 4:21 pm interview with Certified Nursing Aide #1, she confirmed the call light button is draped over the headboard and is not within reach of R #41. CNA #1 stated that call light buttons must be within reach at all times and it did not happen.

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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. Based on record review and interview, the facility failed to ensure 1 (R #107) of 1 (R #107) resident was treated with respect and dignity when the facility failed to ensure that R #107 was not put to bed at night with her shoes on and fully clothed.This deficient practice is likely to result in residents feeling as if they were unimportant and that their preferences do not matter. The findings are: A. On 01/21/23 at 12:40 pm during an interview with R #107's sister (FM) #1, she stated she had been told by her sister (R #107) that she had been put to bed a fully clothed and with her shoes on and she had been upset about it. FM #1 stated that her sister (R #107) likes to be put to bed in her pajamas every night. FM #1 thought this was a concern and her sister was upset that is why she brought it to the facilities attention. B. Record review of R #107's care plan dated 10/02/24 revealed: it is important that she (R #107) has the opportunity to engage in daily routines that are meaningful relative to her preferences. Intervention: It is important for me to choose what clothing to wear.C. On 01/22/26 at 12:59 pm during an interview with Assistant Director of Nursing (ADON), she stated she was familiar with the incident that occurred with R #107 about putting her to bed without changing her into her bed clothing and with her shoes on. ADON further stated that the staff should have changed the resident into her preferred clothing and should not have left her shoes on. D. On 01/23/26 at 10:02 am during an interview with the Social Services Assistant (SSA), she stated R #107 (being put to bed with her fully clothed and her shoes on) was not right and the family had concerns about it and let her know at a care conference that the incident had happened and R #107 was unhappy about being left with her clothing and shoes on. E. On 01/27/26 at 9:18 AM during an interview with Certified Nurse Aide (CNA) #3, she stated, when she came in the morning after the incident (she cannot recall the date) R #107 was upset because another aide had put her to bed and did not put her pajamas on her and she had slept with her shoes on as well. R #107 stated to CNA #3 that the aide had told her she would return to change her and never returned, CNA #3 further stated that that R #107 needs assistance with changing her clothing she is unable to utilize her arm. CNA #3 confirmed that when she came in that morning that R #107 was still wearing her clothing and had not been changed into her pajamas, which she likes to wear every night. CNA #3 did not report the incident to any facility staff and she stated she should have let someone know being that R #107 was very upset.

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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 record review, and interview, the facility failed to complete an accurate Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessment for 1 (R #132) of 1 (R #132) resident reviewed for assessments. This deficient practice could likely result in the residents' preferences and care needs not being met.The findings are:A. Record review of R #132's facesheet revealed she was admitted on [DATE] and discharged to community on 04/15/23 with the following diagnoses (including but not limited to): 1. Unspecified intracapsular fracture of right femur (a type of bone fracture that occurs within the joint capsule, often affecting the hip). 2. Type 2 diabetes mellitus (condition in which the body [NAME] use insulin correctly and sugar builds up in the blood) without complications. 3. Systemic lupus erythematosus (an autoimmune disease in which the body's immune system mistakenly attacks its own healthy cells and tissues, leading to inflammation and damage in various organs and systems), unspecified. 4. Age-related osteoporosis (causes bones to become weak and brittle). 5. Unspecified dementia (is the loss of cognitive functioning that interferes with daily life and activities), unspecified severity, without behavioral disturbance. 6. Muscle weakness (generalized).B. Record review of R #132's progress notes revealed the following: 1. 03/25/23 Nursing notes: skin check completed: right hip dressing. Clean, dry, and intact. 2. 03/27/23 Nursing notes: skin check completed: right hip. 3. 03/28/23 Nursing notes: skin check completed: right hip. 4. 03/31/23 Nursing notes: a skin check was performed: right lower extremity (hands and feet). 5. 04/01/23 Nursing notes: a new pressure wound unstageable due to slough and or eschar in-house acquired. Location: Coccyx was assessed today. 6. 04/15/23 Nursing notes: R #132 family present for wound care and teaching regarding unstageable pressure injury to coccyx (small bone at the bottom of the spine) area.C. Record review of R #132's weekly skin check revealed the following: 1. 03/31/23 : no pressure injury. 2. 04/10/23 : pressure injury to sacrum (bone in lower spine), unstageable due to presence of slough. 3. 04/13/23: unstageable pressure injury to coccyx area, in-house acquired. Record review of R #132's Minimum Data Set revealed (MDS; a federally mandated assessment instrument completed by facility staff) revealed the following: 1. MDS dated [DATE] section M0210: no unhealed pressure ulcers or injuries.E. On 01/27/26 at 11:30am during an interview with the MDS Coordinator, she confirmed R #132's MDS assessment dated [DATE] did not accurately document the unstageable pressure injury to the coccyx area.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 an ongoing program of activities designed to meet the interests for 1 (R #11) of 6 (R #11, R #12, R #48, R #118, R #122, and R #131) residents reviewed for activities by not providing meaningful individualized activities based upon residents' interests. If residents are not provided or encouraged to attend/participate in activities that meet their interests, then they are likely to experience an increase in boredom, isolation, and depression. The findings are: A. Record review of R #11's admission record, no date revealed an admission date of 10/02/25 with the following diagnoses: 1. Hemiplegia and Hemiparesis following Cerebral Infarction affecting left dominant side (is a symptom that involves one-sided paralysis. A left-sided stroke is a stroke that damages the left side of the brain). 2. Essential (primary) Hypertension (high blood pressure, is a common condition where the force of blood against the artery walls is consistently too high). 3. Depression, unspecified (is a mood disorder that causes a persistent feeling of sadness and loss of interest). 4.Type 1 diabetes Mellitus with Hyperglycemia (high blood sugar, also called hyperglycemia, affects people who have diabetes). B. Record review of R #11's admission Minimum Data Set (MDS) assessment dated [DATE] revealed R #11's personal preferences for activities for the following: 1. Listen to music, 2. Pet visits, 3. Groups, 4. Religious Services. C. Record review of R #11's care plan revision dated 12/23/25 revealed R #11's care plan did include her personal preferences, and staff did not follow care plan to provide personal preference activities for R #11. D. Record review of R #11's entire record revealed no documentation for Recreation Participation Record, revealed staff did not follow care plan and show documentation of personal preference activities that occurred for the following personal preferences: 1. Pet visits. 2. Listening to music, 3. Religious Services E. Record review of R #11's entire record revealed no progress notes for recreation individual participation, revealed that no progress notes were completed by staff that activities occurred. F. On 01/22/2026 at 1:03 PM, during an interview with Activities Director (AD), he stated R #11 doesn't speak and is now in isolation. Sensory items putting block in and beads will be offered to her now. AD stated the Regional Activities Director was at the facility at the time R #11 was admitted . AD stated his expectation is that the activities assistants log in the participation sheets, and progress notes, and provide activities to residents in groups and one to ones. G. On 01/22/2026 at 1:12 PM, during an interview, the Regional Activities Director (RAD) stated R #11 was put on one-to-one programs when she was admitted to the facility on [DATE]. RAD stated activities staff are now focusing on one-to-one programs. RAD stated that the AD is learning his job, and RAD will be working with the activity aides providing one-to-one programs. The RAD stated the activities program was not very solid during October 2025-December 2025. R #11 is currently on one-to-one programs, and the RAD stated she completed R #11 admission activity assessment. The RAD's expectation is that she expects the activities staff to do one-to-one activity program with R #11. The RAD stated that the activity staff will be receiving training for activities, and she will work on one-to-one programs moving forward.

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	01/28/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, and interview, the facility failed to meet the professional standards of practice required to prevent skin breakdown for 1 (R #132) of 1 (R #132) resident reviewed for skin assessments when the facility failed to:Ensure a Braden Scale assessment was completed upon admission-Accurately utilize standardized tools such as the Braden Scale (nursing assessment tool used to estimate a patient's risk of developing pressure injuries (pressure ulcers)).-The lack of documented off-loading (Offloading is crucial for preventing pressure ulcers, particularly in individuals with limited mobility or those confined to a bed or wheelchair. By redistributing pressure away from vulnerable areas, offloading helps mitigate the risk of pressure ulcer development) coccyx (tailbone, the last bone at the end of the spine) directly contributed to the tissue necrosis (death of body tissue).These deficient practices led to the development of pressure injury to the coccyx area.The findings are:A. Refer to F0641 for related findings.B. Record review of R #132's Electronic Medical Records (EMR) revealed the following: 1. Braden Scale (a nursing assessment tool used to estimate a patient's risk of developing pressure injuries (pressure ulcers) were done on 04/01/23, 04/08/23, and 04/14/23. Further review of the facility Braden scale instructions was to be completed on resident move-in. 2. No Braden scale assessment was done on R #132 move-in date.C. Record review of R #132's careplan dated 04/28/23 revealed R #132 is at risk for skin breakdown related to decreased activity, impaired cognition, limited mobility, poor safety awareness, incontinence, sheer or friction, informed refusals of care, and recent surgery to the right hip was identified on 03/28/23. Intervention of turn and reposition every 1 to 2 hours was added only 04/01/23. D. On 01/27/26 at 09:02 am during an interview with the Assistant Director of Nursing (ADON), she stated that Braden Scale assessments are done on admission and it did not happen for R #132.

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	325037	A. Building B. Wing	01/28/2026

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Ladera Center	5901 Ouray Road NW Albuquerque, NM 87120

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that resident preferences were honored for 1 (R #104) of 1 (R #104) resident reviewed when:-the facility served green peas despite the resident's dietary profile indicating a preference for no peas.The findings are: A. Record review of R #41's facesheet revealed she was admitted on [DATE] with the following diagnoses (including but not limited to): 1. Parkinson's Disease (progressive neurodegenerative disorder that primarily affects movement and is characterized by symptoms such as tremors, stiffness, and balance difficulties) with dyskinesia (involuntary or uncontrolled movements of the body, which can range from mild tremors to severe, erratic motions). 2. Presence of intraocular lens (artificial lens implanted in the eye to replace the natural lens). 3. Presbyopia (the gradual loss of your eyes' ability to focus on nearby objects). B. On 01/27/26 at 12:40 pm, during on observation in the dining room, R #104 was served beef chili corn chip casserole, flour tortilla, green peas, grapes and hot coffee for lunch with Licensed Practical Nurse (LPN) #5 assisting R #104 with meal. R #104's meal ticket clearly stated, no sides of peas or spinach. Further observation revealed R #104 ate half of the green peas that was served. C. On 01/27/26 at 12:41 pm during an interview with LPN #5, she confirmed that R #104 received a side of green peas on her lunch tray. LPN #5 stated that per R #104's preferences she should not have any peas on her meals and it did not happen. D. On 01/27/26 at 2:22 pm during an interview with the Dietary Manager (DM), he confirmed R #104's dietary preference during lunch and dinner is no sides of peas or spinach, and it did not happen.

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	325037	A. Building B. Wing	01/28/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to :Ensure stored foods are not left open to air.Ensure staff wore beard nets in the kitchen. These deficient practices are likely to affect all 107 residents listed on the census provided by the Administrator on 05/12/25 and may lead to foodborne illnesses in residents if proper food storage and safe food handling practices are not adhered to.The findings are: A. On 01/20/26 at 12:13 pm during an observation of the kitchen revealed one ten-pound box of frozen hamburger patties stored in freezer open to air.B. On 01/20/26 at 12:15 pm during an interview, Dietary Manager (DM) confirmed the ten-pound box of frozen hamburgers was open to air and should not have been left open.C. On 01/27/2026 12:27 pm during an observation of the kitchen revealed that Dietary Aide (DA) #1 was not wearing a beard guard and was serving lunch.D. On 01/27/26 at 12:38 am during an interview, the DM confirmed that DA #1 was not wearing a beard guard and stated that he should have been.