| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 325037 | A. BUILDING _____ B. WING _____ | 10/26/2016 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **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) |
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| F 0329<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | **1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview the facility failed to ensure that 1 (R #1) of 4 (R #s 1, 2, 3, 4) residents reviewed for unnecessary medication did not receive excessive doses of pain medication. This deficient practice caused R #1 to:<br>1. Become unresponsive and had to be administered [MEDICATION NAME] (a medication used to block the effects of opioids/narcotics, especially in overdose) two times while at the facility.<br>2. To be taken by ambulance to the Emergency Department due to the over sedation of [MEDICATION NAME] (a narcotic pain medication).<br>The findings are:<br>A. Record review of the MAR (medication administration record) for July 2016 indicated that R (resident) #1 was taking [MEDICATION NAME] (a narcotic pain medication) Solution 20 MG/ML (milligram/milliliter). Give 0.5 ml (milliliter) by mouth every 1 hour as needed for pain/SOB (shortness of breath).<br>B. Record review of the MAR for July 2016 indicated that R #1 was taking [MEDICATION NAME] HCl ([MEDICATION NAME]) Tablet 10 mg. Give 10 mg by mouth three times a day for pain.<br>C. Record review of the physician's orders [REDACTED].<br>D. Record review of the physician's orders [REDACTED].<br>E. Record review of the MAR for July 2016 indicated that R #1 began receiving 40 mg of [MEDICATION NAME] on 07/20/16 three times per day.<br>F. Record review of the MAR for July 2016 indicated that on 07/22/16, R #1 refused AM dose of [MEDICATION NAME].<br>G. Record review of the MAR for July 2016, indicated that a note was written on 07/23/16 resident request 3 [MEDICATION NAME] instead of 4 stated 4 was too much nurse not (notified).<br>H. Record review of the nursing progress note dated 07/25/16 indicated: rsd (resident) sedated, slurring words, unable to hold head up, eyes droopy and sometimes shut with head bobbing downward, and lethargic, rsd states, 'that is too much, I don't want it all'. PA (Physician Assistant) notified. Orders obtained to give [MEDICATION NAME] 30 mg x1 dose this 0800 am dose. Will f/u (follow up) with provider regarding sedation of resident, will continue to monitor rsd for safety and status changes.<br>I. Record review of the nursing progress note dated 07/25/16 indicated a new order for [MEDICATION NAME] HCl Tablet 10 MG; Give 30 mg by mouth one time only for pain until 07/25/2016 23:59 (11:59 pm) give 30 mg this am only.<br>J. Record review of the nursing progress note dated 07/25/16 at 8:00 am, indicated that nurse notified of rsd. slurring words and apparent look of sedation.<br>K. Record review of the nursing progress note dated 07/25/16 at 13:14 (1:14 pm). The note indicated that at 12:49 pm too lethargic to take meds nurse notified.<br>L. Record review of a progress note dated 07/25/16 at 15:01 (3:01 pm), (Nurse) was called to resident's room. Resident lying on floor on stomach. Resident stated she leaned over in wheelchair and fell to floor. No new open or discolored areas noted at this time. ROM (range of motion) completed WNL (within normal limits). Neuro checks started, WNL. Doctor made aware via NP (nurse practioner), sister made aware. At present no complaints of pain or discomfort. Presently lying in bed. Alert, verbal, pupils equal and reactive, skin warm and dry, resp (respirations) even and unlabored. Will continue to monitor.<br>M. Record review of the physician's progress note dated 07/27/16 stated that R #1 was sent to the ED (emergency department) on 07/25/16 for over sedation due to her scheduled [MEDICATION NAME]. [MEDICATION NAME] was given x 2 at the facility and patient remained unresponsive, so she was sent to the ED. In the hospital she was found to have a CBG (blood glucose) of 48 (Normal range of 80-110), she stated she hadn't eaten all day. She returned yesterday morning and [MEDICATION NAME] dose was decreased from 40 mg TID (three times per day) to 10 mg TID.<br>N. On 10/26/16 at 10:57 am during an interview with Medication Technician #1, she stated that when she saw R #1 on 07/25/16 she was slouched over in her chair. It was very difficult to get her awake. She was almost comatose. PA (Physician's Assistant) #1 was made aware of the situation and had us watching and monitoring R #1. The medication was decreased from 40 mg to 30 mg three times per day.<br>O. On 10/26/16 at 11:50 am, during an interview with RN (Registered Nurse) #1, she stated that on 07/25/16 she found R #1 in the hallway in her wheelchair slouched over. She stated that she was always drowsy but on this day it was particularly bad. Later, she saw R #1 lying flat in bed and she was very hard to wake. RN #1 did an sternal rub (rubbing the chest bone to arouse) on her and she did arouse a bit. RN #1 then reported this to PA #1. She stated that they were tapering her off [MEDICATION NAME] to the [MEDICATION NAME] at this time and she was worried that the [MEDICATION NAME] was building up in her system. She was told to monitor R #1 and when she was still very lethargic and hard to arouse the decision was made by the medical doctor to administer [MEDICATION NAME]. RN #1 stated that this worked and R #1 was sitting up and talking. Around 15 to 30 minutes later she was starting to get groggy again and the second dose of [MEDICATION NAME] was given and she was sent out to the hospital.<br>P. On 10/26/16 at 2:40 pm, during an interview with PA #1 she stated that [MEDICATION NAME] is a stronger narcotic than [MEDICATION NAME]. She stated that the calculation for [MEDICATION NAME] to [MEDICATION NAME] was anywhere from 2:1 [MEDICATION NAME] to [MEDICATION NAME] to 4:1 [MEDICATION NAME] to [MEDICATION NAME] depending on how much [MEDICATION NAME] a person had been getting. |

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