STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325032	A. Building B. Wing	11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandia Ridge Center	2216 Lester Drive NE Albuquerque, NM 87112

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35632 Based on record review, and interview the facility failed to prevent resident to resident abuse for 2 [R #16 and 224] of 5 [R #s 16, 42, 60, 224 and 265] residents reviewed for abuse and neglect by not providing enough supervision for a resident with known sexually inappropriate behaviors and not implementing additional interventions to protect residents. This deficient practice likely resulted in psychosocial harm to residents. The findings are A. Record review of the hospital records for R #265 dated 03/19/21 indicated the following: per CM [Case Manager] note: in process to apply to Office of Guardianship .Recommended discharge to skilled nursing facility. He would not be a safe discharge to his home where he lives alone. He would not be able to identify and or resolve any unsafe situations, or hazards in the home. Like forget the stove was on, burn himself while cooking or take medications wrong. B. Record review of R #265's Care Plan dated 04/20/21 revealed Resident/patient has a tendency to exhibit sexually inappropriate behavior related to: Psychiatric Disorder (s): Schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior). Interventions included :Monitor conditions that may contribute to inappropriate sexual behaviors, including: psychiatric disorder(s), cognitive loss/dementia, CVA (Cerebralvascual Accident, ie. stroke), delirium, delusions, hallucinations, head injury, etc. and Monitor medications for potential contribution to sexually inappropriate behaviors There were no additional events or interventions added. C. Record review of the nursing progress notes for R #265 dated 04/06/21, indicated the following, Received report from CNA [Certified Nursing Assistant] this morning that resident was in his room with his pants down and his hands on his penis playing with himself. He was spraying his bodily fluids on the floor and on the wall. Resident [R #265] came to the entry way of the room and was trying to lure female residents in the room. He was immediately redirected by nursing staff to pull up his pants and clean himself up. This nurse went in to speak to resident regarding situation. It was discussed that his behavior was inappropriate in the hallway. Resident became angry started calling me [staff] a bitch and flipping me off . D. Record review of the nursing progress notes for R #265 dated 04/19/21, Resident refusing medications. Cussing at staff. Stated you girls are mad because your husbands are f'ing other women. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	E. Record review of the nursing progress notes dated 04/20/21, This morning R #265 was in his room with another female resident [R #224] laying on his bed and R #265 was holding her around her waist. When staff entered the room and assisted the female resident out of the room the male resident became irate began to curse at nursing staff. Stated Leave her in my room or I'm going to say that you guys are pushing her. And let's see who gets in trouble. F. Record review of the nursing progress notes dated 05/11/21, Last pm (evening) pt (patient) was seen with pants and underwear off lying in female bed, he was asked to leave but refused, male CNA came got pt dressed and escort him to his room. Pt settled and slept throughout the night. G. Record review of a nursing progress note dated 05/15/21 indicated the following Resident [#16] stated that male resident [R #265] touched her in front and back resident pointed to the area where she was touched .This nurse noticed her brief and pj (pajama) pants were half on and tisted (twisted) [sic] . H. On 10/18/21 at 2:52 pm, during an interview with Family Member [FM] #1, she stated that there was a resident [R #265] to resident [R #16] abuse on May 2021. She stated that resident [R #265] sexually assaulted her mother [R #16] back on May 15, 2021. She stated that R #265 was known to the facility to have sexually inappropriate behaviors by the staff. She stated that the staff told her that they keep an eye on him but at some point they got busy and lost track of him. FM #1 stated that a staff member was checking on the residents and that R #265 peeked out of a female's room and slammed the door when he saw the staff member. The staff member wasn't able to immediately gain entrance into the room because the facility investigation revealed that R #265 was blocking the door. The staff member did get into the room and the resident threw a chair at the staff member [not hitting the staff]. R #265 was asked to leave, and they did get him out of the room. They asked R #16 if he had hurt her, and she indicated that he had sexually touched her. She stated that R #16 was taken to the emergency room and checked out. The hospital staff stated that they did not see any indication of penetration and thought that doing a SANE [sexual abuse nursing exam] evaluation on her would just be traumatizing for her. FM #1 stated she decided not to have a SANE exam done and that she does not believe that her mother suffered any harm from the incident. I. Record review of the nursing progress notes dated 05/15/21, Was called to Dementia unit by the nurse on duty to assist with this resident with behaviors. Upon entering the unit the resident was in the hallway this resident was educated on the ladies can not consent to being touch in any way he ask why not attempted to explain to this resident that it's inappropriate to touch. J. On 10/20/21 at 12:35 pm, during an interview with Certified Nursing Assistant #5 [CNA], she stated that she does remember R #265 and he did have really bad behaviors. R #265 would grab people, both staff and residents. He would stand in the doorway naked, touching himself. She stated that his behavior started right away. When there are three CNA's back here on this unit it helps a lot, they don't have three CNA's back on this unit anymore. She stated that it makes it hard to keep an eye on everyone. CNA #5 stated that R #265 was tall and very strong, he intimidated the staff. She did not like working with him and felt like she needed to protect the other residents from him. She was not working the evening [05/15/21] that the incident with R #265 and R #16 occurred. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	K. On 10/20/21 at 1:30 pm, during an interview with Licensed Professional Nurse [LPN] #7, she stated, R #265 was young, he was in his 50's. He didn't have any family and had memory issues, that is why he was on the unit. He was very perverted, from the day he got here. He would make nasty comments to staff. At first it was directed to staff, then he directed it to residents. She stated that he would stand in his door way naked, he would pee in trash cans. LPN #7 stated that he had expressed a couple of times that he knew what he was doing and was going to do it anyway. LPN #7 stated that she on multiple occasions spoke to the Unit Manager about this and the Center Nursing Executive [CNE] about the behaviors and not being appropriate for that unit. The day of incident 05/15/21 with R #16 he was sent out and was not accepted back to the facility. L. On 10/20/21 at 2:15 pm, during an interview with Unit Manager #1 she stated that she was told about R #265's behaviors. She told the staff to document it. She stated that he was appropriate to be on this unit because he had exit seeking behaviors with some memory issues and that was really the only criteria that a resident would need to meet to be on this unit. She stated that CNA #1 and #5 did come to her with their concerns. She told them to document it. M. On 10/20/21 at 2:23 pm, during an interview with CNA #1, she stated that she does remember R #265. We [the staff] had lots of problems with him. He was aggressive and intimidating. N. On 10/21/21 at 3:02 pm, during an interview with Physician #1, he stated that he saw R #265 in April 2021. R #265 was in his fifties and he did have some dementia and inappropriate sexual behaviors. Physician #1 stated behaviors like this are hard to treat. Can't treat his disinhibition [disinhibition is a lack of restraint manifested in disregard of social conventions, impulsivity, and poor risk assessment. Hypersexuality, hyperphagia, and aggressive outbursts are indicative of disinhibited instinctual drives]. He stated that there are no good medications to treat those that display these types of behaviors. He stated that he searches for medications all the time that might be effective. He stated that this is the best situation you are going to get. There isn't a hospital that you can send him to. You can send him out to places like [mental health hospital] because they will send him right back. He stated that yes at that point you have to monitor and watch him at all times, that would be the only way to ensure other residents safety. O. On 11/23/21 at 8:34 am, during an interview with Admissions, she stated that if they aren't sure about bringing in a resident for the secure unit they will have a meeting about it. The nurse will have input and so will the Center Executive Director and Center Nursing Executive. She stated that the only criteria for for being admitted to the secure unit is that they have to have exit seeking behaviors and memory issues. P. On 11/23/21 at 11:46 am, during an interview with UM #1, it was stated that they [staff] moved him to the unlocked behavioral unit on 04/20/21 for a few days to see how he would do on that unit. He was exiting seeking so they tried a WanderGuard on him, that didn't work because he knew how to push the green button to get out of the facility. So, they put R #265 back on the secure unit. Having more staff on that unit monitoring would have helped and may have prevented the incident.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37426 Based on observation, record review, and interview, the facility failed to ensure that bathing/showering assistance was provided for 3 (R #14, 115, and 271) of 3 (R #14, 115, and 271) residents reviewed for ADLs (activities of daily living). This deficient practice could likely result in residents in need of this specialized care to experience a decline in their ability to perform hygiene tasks and/or maintain good personal hygiene. The findings are: Findings for R #14 A. Record review R #14's face sheet revealed, admitted [DATE], and diagnoses included: encephalopathy (injured or damaged brain), hydronephrosis with renal and ureteral calculous obstruction (swelling of the kidney, which is the organ responsible for filtering blood and removing waste from the body due to inability to drain urine), moderate protein-calorie malnutrition (not eating enough protein calories), dysphasia oropharyngeal phase (swallowing difficulties), exposure to covid-19 (highly infectious viral disease), pressure ulcer of sacral region (bottom of the spine) stage 4 (has reached through the skin to muscle, bone, or tendons), gastronomy status/gastrostomy-tube (tube inserted through the belly that brings nutrition directly to the stomach), colostomy status (surgical procedure in which a portion of the large intestine, or colon, is brought through the belly to carry waste out of the body), hyperlipidemia (high level of fats in the blood), major depressive disorder (loss of pleasure or interest in life), retention of urine (the bladder, which stores urine doesn't empty all the way when you urinate). B. Record review R #14's care plan dated 07/12/21 revealed, Focus: [name of resident] is at risk for decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: recent illness with hospitalization resulting in fatigue, activity intolerance and confusion. C. Record review of shower/bath report for R#14 dated from 10/07/21 to 10/20/21 revealed R #14 did not receive shower or bed bath on 10/07/21 and 10/18/21. D. On 10/18/21 at 9:48 am, during an interview and observation of R #14, she was wearing a bed gown with old food stains. Hair was dirty, greasy, and uncombed. During an interview with R #14, R #14 stated, I have not had my gown changed for a couple of days. I cannot remember when I last received a bed bath. I should have a bed bath twice a week. Findings for R #115 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Record review R #115's face sheet revealed, admitted [DATE], and diagnosis included: Chronic diastolic congestive (heart failure), type 2 diabetes mellitus (high levels of sugar in the blood) with diabetic nephropathy (nerve pain), morbid severe obesity (high percentage of body fat), nonrheumatic mitral (heart valve does not close properly), encounter for screening for upper gastrointestinal (esophagus, stomach, and small intestines) disorder, paroxysmal atrial fibrillation (irregular heartbeat), muscle weakness, hypothyroidism (abnormally low activity of the thyroid gland), contact with and suspected exposure to covid-19, obstructive sleep apnea (repeatedly stopping and starting breathing while sleeping), chronic kidney disease stage 3 (moderate kidney damage and loss of kidney function), constipation (difficulty in emptying the bowels), adult failure to thrive (progressive functional decline), major depressive disorder, peripheral vascular disease (narrowing of blood vessels). F. Record review R #115 care plan dated 10/04/21 revealed, Focus: [name of resident] is at risk for decreased ability to perform ADLs in: bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting. Resident recent illness with hospitalization resulting in fatigue, activity intolerance and confusion. G. Record review of shower/bath report for R #115 dated from 10/07/21 to 10/20/21 revealed, R #115 did not receive showers or bed-baths on 10/09/21, 10/13/21, and 10/16/21, and 10/20/21. H. On 10/18/21 at 10:14 am, during an interview and observation of R #115, she was wearing a bed gown, hair was greasy, and uncombed. R #115, stated, They (staff) did not have time to bath me, on Saturday (10/16/21) telling me they (staff) are doing 25 showers a day. They do not have time to shower me. I am a hoyer lift (an assistive device that allows patients to be transferred between a bed and a chair or other similar resting places, by the use of electrical or hydraulic power) resident and prefer to be in the shower. I do not like bed baths. I am not really sure when I last had a shower. Findings for R #271 I. Record review of R #271's face sheet, revealed admitted [DATE]. Admission diagnoses included: traumatic hemopneumothorax sequela (penetrating wound to the chest that interferes with lung function), fracture of lumbar vertebra (injury to the spinal cord), multiple fractures of ribs right side sequela, contact with and suspected exposure to covid-19. J. Record review of R #271's care plan dated 10/14/21 revealed, Focus: [name of resident] requires assistance is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting, related to: recent hospitalization impaired balance/dizziness. K. Record review of shower/bath report for R #271 dated from 10/14/21 to 10/20/21 revealed R #115 did not receive showers or bed-baths on 10/14/21, and 10/18/21. L. On 10/18/21 at 10:42 am, during an interview and observation of R #271, she was wearing a bed gown, hair had not been combed and her hair was matted together and greasy looking. During an interview with R #271, she stated, I have been wondering about when my shower would be. I have asked when it would be and the CNAs (certified nursing assistance) are not sure when it will be, that is what they told me when I came into the facility. Then I found out my showers are on Wednesday and Saturday. Saturday night (10/16/21) the CNA was on her own and she said only one CNA on the floor, one called in (not coming to work) and she did not know where the other CNA was. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. On 10/20/21 at 1:45 pm, during an interview with CNA #2, she stated, It is chaotic on Monday and Tuesdays. We did give somebody a bed bath today. There is only 2 CNA's assigned on this skilled hall (400). I have been working here for about 3 weeks and did asked yesterday (10/19/21) for more help on this hall and we were given a shower aid today. We have 5 room changes (residents to be moved to another room) today and was able to do one resident move to another room. N. On 10/20/21 at 3:30 pm, during an interview with CNA #4, she stated, We have 5 to 6 showers to do a day on this hall. If we don't get them the showers/bed baths done we make a note. We try to do the best we can. Does not always happen that we can get the showers/bed baths completed. I have been working for 3 weeks that's about 10 days in the facility. We need 2 people to use the Hoyer lift which limits us to answer the call lights. We have 4 to 5 residents requiring the Hoyer lift. I did not have a lunch break yesterday and have only one 15 minute break today. O. On 10/21/21 at 3:37 pm, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that R#14, 115 and 271, have not been receiving showers/bed baths on their scheduled days.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37426 Based on observation, record review, and interview, the facility failed to provide a sufficient amount of nursing staff to meet the needs of 5 (R #14, 16, 115, 224 and 271) of 5 (R #14, 16, 115, 224 and 271) resident reviewed for ADLs (Activities of Daily Living) and abuse by not having enough licensed nursing staff and Certified Nursing Assistants (CNA's) to: 1. Provide showers per resident preference and need. 2. Provide required supervision on the secured unit needed to prevent resident to resident sexual abuse. This deficient practice could likely resulted in residents not receiving their required care and likely resulted in psychosocial harm on the secured unit. The findings are: Findings related to bathing: Findings for R #14 A. Record review R #14's face sheet revealed, admitted [DATE], and diagnoses included: encephalopathy (injured or damaged brain), hydronephrosis with renal and ureteral calculous obstruction (swelling of the kidney, which is the organ responsible for filtering blood and removing waste from the body due to inability to drain urine), moderate protein-calorie malnutrition (not eating enough protein calories), dysphasia oropharyngeal phase (swallowing difficulties), exposure to covid-19 (highly infectious viral disease), pressure ulcer stage 4 (has reached through the skin to muscle, bone, or tendons), of sacral region (bottom of the spine), gastronomy status/gastrostomy-tube (tube inserted through the belly that brings nutrition directly to the stomach), colostomy status (surgical procedure in which a portion of the large intestine, or colon, is brought through the belly to carry waste out of the body), hyperlipidemia (high level of fats in the blood), major depressive disorder (loss of pleasure or interest in life), retention of urine (the bladder, which stores urine doesn't empty all the way when you urinate). B. Record review R #14's care plan dated 07/12/21 revealed, Focus: [name of resident] is at risk for decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to: recent illness with hospitalization resulting in fatigue, activity intolerance and confusion. C. Record review of shower/bath report for R#14 dated from 10/07/21 to 10/20/21 revealed R #14 did not receive shower or bed bath on their scheduled days 10/07/21 and 10/18/21. D. On 10/18/21 at 9:48 am, during an interview and observation of R #14, she was wearing a bed gown with old food stains and hair was dirty, greasy, and uncombed. During an interview with R #14, she stated, I have not had my gown changed for a couple of days. I cannot remember when I last received a bed bath. I should have a bed bath twice a week. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Findings for R #115 E. Record review R #115's face sheet revealed, admitted [DATE], and diagnosis included: Chronic diastolic congestive (heart failure), type 2 diabetes mellitus (high levels of sugar in the blood) with diabetic nephropathy (nerve pain), morbid severe obesity (high percentage of body fat), nonrheumatic mitral (heart valve does not close properly), encounter for screening for upper gastrointestinal (esophagus, stomach, and small intestines) disorder, paroxysmal atrial fibrillation (irregular heartbeat), muscle weakness, hypothyroidism (abnormally low activity of the thyroid gland), contact with and suspected exposure to covid-19, obstructive sleep apnea (repeatedly stopping and starting breathing while sleeping), chronic kidney disease stage 3 (moderate kidney damage and loss of kidney function), constipation (difficulty in emptying the bowels (intestine)), adult failure to thrive (progressive functional decline), major depressive disorder, peripheral vascular disease (narrowing of blood vessels). F. Record review R #115 care plan dated 10/04/21 revealed, Focus: [name of resident] is at risk for decreased ability to perform ADLs in: bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting. Resident recent illness with hospitalization resulting in fatigue, activity intolerance, and confusion. G. Record review of shower/bath report for R #115 dated from 10/07/21 to 10/20/21 revealed, R #115 did not receive scheduled showers or bed-baths on 10/09/21, 10/13/21, 10/16/21, and 10/20/21. H. On 10/18/21 at 10:14 am, during an interview and observation of R #115, she was wearing a bed gown, hair was greasy, and uncombed. R #115, she stated, They (staff) did not have time to bathe me on Saturday (10/16/21) telling me they (staff) are doing 25 showers a day. They do not have time to shower me. I am a Hoyer lift (an assistive device that allows patients to be transferred between a bed and a chair or other similar resting places, by the use of electrical or hydraulic power) resident and prefer to be in the shower. I do not like bed baths. I am not really sure when I last had a shower. Findings for R #271 I. Record review of R #271's face sheet, revealed admitted [DATE]. Admission diagnoses included: traumatic hemopneumothorax sequela (penetrating wound to the chest that interferes with lung function), fracture of lumbar vertebra (injury to the spinal cord), multiple fractures of ribs right side sequela, contact with and suspected exposure to covid-19. J. Record review of R #271 care plan dated 10/14/21 revealed, Focus: [name of resident] requires assistance is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting, related to: recent hospitalization impaired balance/dizziness. K. Record review of shower/bath report for R #271 dated from 10/14/21 to 10/20/21 revealed R #271 did not receive showers or bed baths on Thursday 10/14/21, and Monday 10/18/21. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	L. On 10/18/21 at 10:42 am, during an interview and observation of R #271, she was wearing a bed gown, hair had not been combed and her hair is matted together and greasy looking. During an interview with R #271, she stated, I have been wondering about when my shower would be. I have asked when it would be and the CNAs (Certified Nursing Assistance) are not sure when it will be, that is what they told me when I came into the facility. Then I found out my showers are on Wednesday and Saturday. Saturday night (10/16/21) the CNA was on her own and she said only one CNA on the floor, one called in (not coming to work) and she did not know where the other CNA was. M. On 10/20/21 at 01:45 pm, during an interview with CNA #2, she stated, It is chaotic on Monday and Tuesdays. We did give somebody a bed bath today. There is only 2 CNA's assigned on this skilled hall (400). I have been working here for about 3 weeks and have asked yesterday (10/19/21) for more help on this hall and we were given a shower aid today. We have 5 room changes (residents to be moved to another room) today and was able to do one so far. N. On 10/20/21 at 03:30 pm, during an interview with CNA #4, she stated, We have 5 to 6 showers to do a day on this hall. If we don't get them the showers/bed baths done we make a note. We try to do the best we can. Does not always happen that we can get the showers/bed baths completed. I have been working for 3 weeks that's about 10 days in the facility. We need 2 people to use the Hoyer lift which limits us to answer the call lights. We have 4 to 5 residents requiring the Hoyer lift. I did not have a lunch break yesterday and have only one 15 minute break today. Our nurse do not pay attention to us (CNA). The nurse is not in the hallway and does not help with the call lights. She mainly sits up at the nurse's station. The med techs are too busy is help us. We have residents that are wanderers (residents trying to leave) on our hall and we don't get any help getting them out of other resident's rooms. The resident on the end is a new admit and we have to keep the door closed because he is in quarantine and he does not know how to use the call button. We are supposed to check on him every 15 minutes but how are we supposed to do that? We do not have the time for him, he is a fall risk, and we can't hear him. We are scared for him. Right now, you see all the lights on and we have 2 people waiting to be put back to bed. They (residents) are both a 2-person transfer. O. On 10/21/21 at 03:37 pm, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that R #14, 115 and 271, have not been receiving showers/bed baths on their scheduled days. P. On 10/22/21 at 11:34 am, during an interview, CNA #6 stated There are usually two CNA's per hall. I don't think that's enough CNA's because we have some residents who are one-on-one [requiring 1 staff member to provide constant supervision/assistance per resident] or need a lot of attention. Everybody is busy and its hard to get to the residents on time. We have requested more CNA's and they claim to be training some. Q. On 10/22/21 at 12:07 pm, during an interview, LPN (Licensed Practical Nurse) #1 stated Staffing is sometimes short. Yesterday, there were three admissions, and I had a patient who needed a wound vac [a method of decreasing air pressure around a wound to assist the healing by placing a vacuum pump to create negative pressure around the wound] so I had to ask the manager to help me care for the other residents. (continued on next page)

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	325032	A. Building B. Wing	11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandia Ridge Center	2216 Lester Drive NE Albuquerque, NM 87112

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F 0725 Level of Harm - Actual harm Residents Affected - Few	R. On 10/25/21 at 1:05 pm, during an interview, LPN #2 stated There are times that you have to assist with other units, and there are times where there is only one CNA on the floor, like weekends or the night shift. This makes it hard . When there is 1 CNA, it makes it difficult to do showers and dining. This slows the process of getting drinks and feeding. It's been a consistent issue. A lot of times, the staff call in. S. On 10/26/21 at 4:09 pm, during an interview, CNA #7 stated I'm all over the building, I fill in a lot. On this hall, 400, there's one other CNA helping. It's a heavy hall. I wish there were more of us but I go where I can, I can't be in 2 places at once. It's tough to provide quality care. T. On 10/26/21 at 4:26 pm, during an interview with the Staffing Coordinator, when asked how the number of CNA's to schedule on each hall is determined, she replied, There are usually two CNA's per hall. They [administration] have started talking about putting three people instead of two on 100 and 400. In the last couple of days, they requested more help for the 100 hall and the 400 hall. The 400 needs more care to deliver. The need for the additional person on the 400 hall came to my attention about late last week. Honestly, its either [NAME] or famine [alternating, extremely high and low degrees of prosperity, success, volume of business, etc.]. When asked to explain the process for call-in's [when a staff member who is scheduled to work is unable to work as scheduled], she stated, If someone calls-in, I call the people who are off. I put the staffer link into our agency platform and then reach out to our people who are off. Then I usually will find out who [which staff members] I can move where [within the halls] to best accommodate our patients. The residents [and their needs] are always going to be different. When asked to describe how the acuity (level of intensity of care required by the resident's condition) of the hall effects the amount of staff on the schedule, she stated nursing will let me know, we have our two daily meetings, and we are informed of what needs to be done or if other halls need more help. 35632 Findings related to supervision on the secured unit: U. Record review of R #265's Care Plan dated 04/20/21 revealed Resident/patient has a tendency to exhibit sexually inappropriate behavior related to: Psychiatric Disorder (s): Schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior). Interventions included :Monitor conditions that may contribute to inappropriate sexual behaviors, including: psychiatric disorder(s), cognitive loss/dementia, CVA (Cerebralvascual Accident, ie. stroke), delirium, delusions, hallucinations, head injury, etc. and Monitor medications for potential contribution to sexually inappropriate behaviors There were no additional events or interventions added. V. Record review of the nursing progress notes for R #265 dated 04/06/21, indicated the following, Received report from CNA [Certified Nursing Assistant] this morning that resident was in his room with his pants down and his hands on his penis playing with himself. He was spraying his bodily fluids on the floor and on the wall. Resident [R #265] came to the entry way of the room and was trying to lure female residents in the room. He was immediately redirected by nursing staff to pull up his pants and clean himself up. This nurse went in to speak to resident regarding situation. It was discussed that his behavior was inappropriate in the hallway. Resident became angry started calling me [staff] a bitch and flipping me off . (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	W. Record review of the nursing progress notes dated 04/20/21, This morning R #265 was in his room with another female resident [R #224] laying on his bed and R #265 was holding her around her waist. When staff entered the room and assisted the female resident out of the room the male resident became irate began to curse at nursing staff. Stated Leave her in my room or I'm going to say that you guys are pushing her. And let's see who gets in trouble. X. Record review of the nursing progress notes dated 05/11/21, Last pm (evening) pt (patient) was seen with pants and underwear off lying in female bed, he was asked to leave but refused, male CNA came got pt dressed and escort him to his room. Pt settled and slept throughout the night. Y. Record review of a nursing progress note dated 05/15/21 indicated the following Resident [#16] stated that male resident [R #265] touched her in front and back resident pointed to the area where she was touched .This nurse noticed her brief and pj (pajama) pants were half on and tisted (twisted) [sic] . Z. On 10/18/21 at 2:52 pm, during an interview with Family Member [FM] #1, she stated that there was a resident [R #265] to resident [R #16] abuse on May 2021. She stated that resident [R #265] sexually assaulted her mother [R #16] back on May 15, 2021. She stated that R #265 was known to the facility to have sexually inappropriate behaviors by the staff. She stated that the staff told her that they keep an eye on him but at some point they got busy and lost track of him. FM #1 stated that a staff member was checking on the residents and that R #265 peeked out of a female's room and slammed the door when he saw the staff member. The staff member wasn't able to immediately gain entrance into the room because the facility investigation revealed that R #265 was blocking the door. The staff member did get into the room and the resident threw a chair at the staff member [not hitting the staff]. R #265 was asked to leave, and they did get him out of the room. They asked R #16 if he had hurt her, and she indicated that he had sexually touched her. She stated that R #16 was taken to the emergency room and checked out. The hospital staff stated that they did not see any indication of penetration and thought that doing a SANE [sexual abuse nursing exam] evaluation on her would just be traumatizing for her. FM #1 stated she decided not to have a SANE exam done and that she does not believe that her mother suffered any harm from the incident. AA. On 10/20/21 at 12:35 pm, during an interview with Certified Nursing Assistant #5 [CNA], she stated that she does remember R #265 and he did have really bad behaviors. R #265 would grab people, both staff and residents. He would stand in the doorway naked, touching himself. She stated that his behavior started right away. When there are three CNA's back here on this unit it helps a lot, they don't have three CNA's back on this unit anymore. She stated that it makes it hard to keep an eye on everyone. CNA #5 stated that R #265 was tall and very strong, he intimidated the staff. She did not like working with him and felt like she needed to protect the other residents from him. She confirmed that she was not working the evening [05/15/21] that the incident with R #265 and R #16 occurred. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	BB. On 10/20/21 at 1:30 pm, during an interview with Licensed Professional Nurse [LPN] #7, she stated, R #265 was young, he was in his 50's. He didn't have any family and had memory issues, that is why he was on the unit. He was very perverted, from the day he got here. He would make nasty comments to staff. At first it was directed to staff, then he directed it to residents. She stated that he would stand in his door way naked, he would pee in trash cans. LPN #7 stated that he had expressed a couple of times that he knew what he was doing and was going to do it anyway. LPN #7 stated that she on multiple occasions spoke to the Unit Manager about this and the Center Nursing Executive [CNE] about the behaviors and not being appropriate for that unit. The day of incident 05/15/21 with R #16 he was sent out and was not accepted back to the facility. CC. On 10/20/21 at 2:23 pm, during an interview with CNA #1, she stated that she does remember R #265. We [the staff] had lots of problems with him. He was aggressive and intimidating. You had to watch him. DD. On 10/21/21 at 3:02 pm, during an interview with Physician #1, he stated that he saw R #265 in April 2021. R #265 was in his fifties and he did have some dementia and inappropriate sexual behaviors. Physician #1 stated behaviors like this are hard to treat. Can't treat his disinhibition [disinhibition is a lack of restraint manifested in disregard of social conventions, impulsivity, and poor risk assessment. Hypersexuality, hyperphagia, and aggressive outbursts are indicative of disinhibited instinctual drives]. He stated that there are no good medications to treat those that display these types of behaviors. He stated that he searches for medications all the time that might be effective. He stated that this is the best situation you are going to get. There isn't a hospital that you can send him to. You can send him out to places like [mental health hospital] because they will send him right back. He stated that yes at that point you have to monitor and watch him at all times, that would be the only way to ensure other residents safety. EE. On 11/22/21 at 11:46 am, during an interview with UM (Unit Manager) #1 regarding the secured unit, They need more staff back there. The staff on that unit are great but having one more CNA on that unit would cover all the areas on that unit. After a meal the residents will wander out of the dining room and start walking up and down the hall and this can be the time when altercations can occur. There needs to be someone monitoring the hallway when the other two CNA's are assisting with eating, but it isn't just at meal time, the CNA's working back there could use the help with showering, ADL's [activities of daily living] changing briefs and just keeping on eye on everyone. Most of them are mobile and wander around a lot. Having more staff on that unit monitoring would have helped and may have prevented the incident on 05/15/21 with R #16 and R #265. Findings related to observations on the secured unit: FF. On 10/21/21 at 9:30 am, an observation was made of one CNA #8 hall. CNA #8 was in the dining room with most of the residents. The nurse was at the front desk, RN #10. The other CNA was taking a break. The CNA was observed around 10 minutes later taking a resident down the shower room for their shower. At this time the other CNA assigned to the hall was not back from break and the nurse was still at the front desk. The residents were left unattended at this time. (continued on next page)

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