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	08/12/2022

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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(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 - Minimal harm or potential for 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. 33768 Based on record review, observation and interview the facility failed to provide the appropriate supervision to prevent abuse for 1 (R #1) of 2 (R #1 and 2) residents reviewed for abuse when R #1 with known history of wandering into other resident's rooms, was able to wander into another resident's room and undress without staff noticing. This deficient practice likely put resident at risk of sexual contact with another resident without the ability to consent. The findings are: A. Record review of R #1 progress note revealed the following: 1. 01/30/22 Resident found in another room sitting on the floor next to the bed. 2. 03/15/22 at approx (approximately) 1950 (7:50 pm) hrs (hours) this female resident was found by CNA (Certified Nurse Aide) #1 [CNA #2] in male resident bed with her pants and panties off. The female resident was dressed by CNA #1 and immediately removed from the male resident's room and the incident was reported to RN (Registered Nurse) charge nurse over the hall. Charge nurse had CNA #2 [CNA #3] to take female resident into the dining area for 1:1 direct observation 3. 03/17/22 Pt (patient) is unable to sit still and is still wandering and entering other Pts (patients) room but is easily redirected with assistance. B. Record review of the Care Plan for R #1 dated 03/19/22 revealed [Name of R #1] has a tendency to want to hold hands with other residents and will go into other residents rooms related to: cognitive loss/dementia (symptoms that affect memory, thinking and interferes with daily life) with a focus on a male resident. Interventions include monitor resident form [sic] going into other residents rooms and divert resident by giving alternative objects or activities. C. On 08/11/22 at 9:38 am during interview with R #1's husband, he stated that R #1 wanders into other people's rooms. They found her [R #1] in a guy room and she was laying on the bed, naked and the guy was standing besides the bed with his pants down. Don't know if anything happened. That gives an idea that they [staff] are not checking when they are suppose to be checking [on residents]. (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 - Minimal harm or potential for actual harm Residents Affected - Few	D. On 08/11/22 at 3:31 pm during interview with Licensed Practical Nurse (LPN) #1 she reported that R #1's dementia has progressed a lot. LPN #1 confirmed that R #1 needs assistance with bathing and dressing. When asked if R #1 could undress herself, she confirmed that she could not. When asked how R #1 ended up in another resident's room undressed without being noticed, LPN #1 stated, That's a good question. Regarding staffing on the dementia unit, LPN #1 stated they usually always have 2 CNAs however a third CNA would be very beneficial. E. On 08/12/22 at 11:34 am during interview with the Director of Nursing (DON), he confirmed that he was working on the dementia unit on 03/15/22 along with two other CNAs. Regarding the incident, he stated My CNA (CNA #2) came to me and said she found them [R #1 and R #5] in [Name of R #5]'s rooms. She was on the bed and had her pants down. DON confirmed that R #1 would not be able to undress herself, and although R #1 can take her socks off and pull up her pants, he wasn't sure if she would be able to pull her pants down and remove her brief herself. DON confirmed R #1 does have a history of wandering into other residents' room and staff are expected to be aware where residents are and redirect them back to safe or common areas. F. On 08/12/22 at 12:24 pm to 12:40 pm, R #1 was observed sitting at a table alone. R#1 was observed to get up from the table and slowly shuffle [double steps with left foot] into the hallway while staff were passing out lunch trays. Approximately 6 minutes later, R #1 returned to the dining room. During observation, staff did not attempt to redirect R #1 back to the dining room and while R #1 was in the hallway, no staff were observed to be monitoring R #1. G. On 08/16/22 at 11:08 am during interview with CNA #2 regarding the incident on 03/15/22, she reported that it was about 7 [pm] something and her co-worker was in the dining room passing snacks to residents and she was going room to room assisting residents to bed. When she got to R #5's room, the door was closed and when she tried opening the door, R #5 pushed the door closed. She pushed the door open and saw R #1 laying on the bed with her pants pulled down and her brief on the floor. CNA #2 reported that she had recently changed R #1's brief and that R #1 was not able to undress herself. CNA #2 stated that with only 2 CNAs it is hard to watch all the residents. H. On 08/17/22 at 2:18 pm during interview with the DON, he reported that on the evening of 03/15/22, he was passing medications in the dining room while CNA #2 was handing out snacks to the residents and CNA #2 was helping residents get ready for bed. DON reported that he didn't feel there was any negligence.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 33768 Based on observation, record review and interview, the facility failed to ensure that an allegation of staff to resident abuse was reported within 24 hours to the State Agency for 1 (R #2) of 1 (R #2) resident reviewed. If the facility is not immediately reporting allegations of abuse and conducting an investigation, residents are likely to be at risk of further abuse. The findings are: A. On 08/11/22 at 3:07 pm during interview with R #2 she reported that a couple weeks ago a Certified Nurse Aide (CNA) was rough with her and grabbed her arm causing bruising. R #2 pulled out her cell phone and showed a picture dated 07/13/22 that identified 2 large bruises on her right arm, one bruise near the wrists and one bruise on the forearm. R #2 confirmed that the incident occurred the day before the picture was taken (07/12/22). R #2 confirmed that she told the Physician about the bruising and other staff members. R #2 was unable to provide names of the staff members she informed. R #2 did not provide the name of the CNA however she confirmed that this CNA is still working and she is afraid this CNA will work with her. B. On 08/12/22 at 11:34 am during interview with the Director of Nursing (DON), he confirmed that he was notified about R #2's bruising for the first time yesterday (08/11/22) and he submitted a facility self report to the State Agency on 08/11/22. DON confirmed that the CNA identified by R #2 was suspended pending an investigation. C. Record review of the Physician Progress Note dated 07/18/22 identified that Physician #1 assessed R #2 on this date. The bruising on R #2 arm was not mentioned in the report. D. On 08/18/22 at 10:15 am during interview with Physician #1, she stated that she saw the bruising on R #2 during an evaluation and she asked the resident what happened. Per Physician #1, R #2 reported that staff were rough with her. Physician #1 confirmed that she did not report this to the facility Administration because R #2 told her she had already reported it.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 33768 Based on record review and interview, the facility failed to provide a written 30 day discharge notice for 1 (R #5) of 1(R #5) resident reviewed when R #5 was transferred to the hospital and the Administrator indicated that they would not accept him back. This deficient practice likely resulted in the resident's inability to appeal discharge decision and secure alternative housing. The findings are: A. Record review of R #5's progress noted revealed the following: 1. R #5 was admitted to the dementia unit on 03/09/22 for neurological disease. 2. 03/16/22: Approximately around 19:50 (7:50 PM) CNA #1 [CNA #2] upon doing rounds found female resident in male resident room in bed undressed. The male resident was trying to keep the CNA #1 from entering the room by holding the door close so that CNA #1 could not enter. Immediately the Charge nurse on the hall was notified of the findings regarding the female being found undressed in male resident's bed and male resident pants being down. The female resident was dressed by CNA# 1 and escorted to the dining room for direct observation by CNA#2 [CNA #3]. CNA #1 was then placed as a 1:1 for direct observation over male resident while he remained in his room. 3. 03/16/22: Notified residents son of incident that occurred on Tuesday March 15th. Night nurse attempted to call but no answer. Explained that resident was transported to [Name of hospital] for psych (Psychological) evaluation. He started asking questions about incident. Due to HIPPA (Law that restricts access to individuals' private medical information) I carefully explained what occurred. He asked if we have proof or footage in the halls. I said no we do not have cameras. He was asking the name of the victim and her cognition. I explained I couldn't tell him that information. I let him know where his father was at. He said I want to know details were they naked? Were they caught in the act? I did explain that he can not be readmitted due to the severity of the situation. He said is it at this [name of Corporate]. I explained that all [Name of Corporate] facilities have the same policy. He said how do you know the act was not consensual? I said the cognition of the resident [R #1] would not allow her to consent. B. On 08/12/22 at 9:03 am during interview with the interim Administrator, she confirmed that there was no transfer or discharge notice provided to R #5.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 33768 Based on record review and interview, the facility failed to ensure that the care plan was updated for 1 (R #1) of 1 (R #1) resident reviewed for falls, following (2) falls and did not include an implemented intervention. If the facility is not updating the care plan to reflect residents current status and interventions, residents may not get the care and assistance they need. The findings are: A. Record review of the progress notes for R #1 revealed: 1. 06/30/22: Resident was found sitting on the floor adjacent to her bed, her arms folded against her knees. She was alert and oriented to self and could obey simple commands. Upon assessment she had a bruise on the right side of the forehead above the right upper eyelid, the area is swollen. Baseline vitals including neuro (neurological) checks were done and ranging normal, resident was assisted to bed and made comfortable. The NP (Nurse Practitioner) on call was notified and recommended to monitor the resident and if there are any changes she should be notified. 2. 07/18/22: Resident was found assuming a prone position (position of the body lying face down) after she rolled down from her bed. According to the roommate. She was lying down on her linen she has a small bruise on the left wrist. Resident was assisted to bed and made comfortable. NP on call, spouse and DON (Director of Nursing) were notified, neuro and vitals are stable. B. On 08/11/22 at 9:38 am during observation and interview with R #1's husband, he stated that R #1 has fallen 2 or 3 times and the last time she fell she had a black eye. During observation, R #1 and her husband were sitting on R#1's bed. The bed was in the lowest position. R #1's husband said the bed is always in the lowest position. C. Record review of the Care Plan for R #1 dated 10/08/20 and latest revision 03/16/22 identified that [Name of R #1] is at risk for falls R/T (related to) cognitive loss, lack of safety awareness and polypharmacy (using multiple drugs to treat a single condition). No fall dates were identified on the care plan. The care plan did not identify that the bed should be lowered. D. On 08/11/22 at 3:31 pm during interview with Licensed Practical Nurse (LPN) #1 she said that she and CNAs are very involved with the residents and that they implement needed interventions. When asked who updates the care plan, she said that she can. When asked if R #1's care plan reflects her falls and the intervention of low bed, LPN #1 confirmed that it did not. E. On 08/12/22 at 1:25 pm during interview with the DON, he reported that care plans are updated in the morning meeting and they are trying to add date of falls into the care plan. DON confirmed a lower bed should be included in the care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33768 Based on record review and interview, the facility failed to provide treatment and care in accordance with professional standards of practice for 2 (R #1 and R #3) of 4 (R #1-4) residents reviewed for care by: 1. Not ensuring R #3 received feeding assistance required. 2. Not monitoring for fluid intake and signs of dehydration for R #3 3. Not conducting neurochecks following unwitnessed falls for R #1 These deficient practices could likely result in poor health outcomes for residents. The findings are: Findings related to Nutrition and hydration: A. Record review of the Minimum Data Set (MDS) dated [DATE] revealed that R #3 required limited assistance with one person physical assist for eating (how resident eats and drinks). B. Record review of Drink/Snack and Meal documentation report dated 05/24/22 until 06/12/22 revealed the following: 1. Only identifies if drink accepted by Y for yes but does not identify how much fluid was received. 2. Eating assistance documentation ranges from Limited Assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance) to Extensive Assistance (resident involved in activity, staff provide weight-bearing support) to Total Dependence (Full staff performance). C. Record review of occupational therapy (OT) notes dated 06/06/22 revealed, Patient displays dehydration, notified nursing of patient's hydration status. D. Record review of Nursing Notes dated 06/06/22 did not identify any hydration interventions. E. On 08/11/22 at 11:28 am during interview with R #3's daughter, she stated that during a visit she saw a tray of cold oatmeal left in her mother's room uneaten, No one had assisted her [to eat]. No one had fed her. Staff didn't know she needed assistance. F. On 08/11/22 at 4:16 pm during interview with Speech/Therapy Director he reported that he only saw her (R #3) for 3 sessions, but she could not feed herself or drink herself. When asked if R #3 would be able to reach for a cup of water and bring it to her mouth, he stated No. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 08/12/22 at 11:34 am during interview with the DON, when asked if there was any evidence that the nurse responded to the OT concern related to dehydration on 06/06/22, the DON reviewed the resident record and confirmed that there was no evidence that the nurse did anything at address dehydration. DON looked at the name of the nurse on duty that day and stated that it was an Agency Nurse. H. Record review of Hospital History and Physical dated 06/12/22 revealed concerned by presence of hypernatremia (increased sodium in the blood) indicating inadequate hydration. Findings related to Neurochecks: I. Record review of the Neurological Evaluation Policy and Procedure revised 06/01/21 revealed Neurological evaluation will be performed as indicated or ordered. When a patient sustains an injury to the head or face and/or has an unwitnessed fall, neurological evaluation will be performed: Every 15 minutes x (times) two hours, then every 30 minutes x two hours, then every 60 minutes x four hours, then every eight (8) hours until at least 72 hours has elapsed. J. Record review of the progress notes for R #1 revealed: 1. 06/30/22: Resident was found sitting on the floor adjacent to her bed, her arms folded against her knees. She was alert and oriented to self and could obey simple commands. Upon assessment she had a bruise on the right side of the forehead above the right upper eyelid, the area is swollen. Baseline vitals including neuro (neurological) checks were done and ranging normal, resident was assisted to bed and made comfortable. The NP (Nurse Practitioner) on call was notified and recommended to monitor the resident and if there are any changes she should be notified. 2. 07/18/22: Resident was found assuming a prone position after she rolled down from her bed. According to the roommate. She was lying down on her linen, she has a small bruise on the left wrist. Resident was assisted to bed and made comfortable. NP on call, spouse and DON (Director of Nursing) were notified, neuro and vitals are stable. K. Record review of the Neurological Evaluation for R #1 revealed: 1. Evaluations started at 5:15 am on 06/30/22 until 6:00 am after which only vital signs were documented until 1:15 pm. There was no evaluation for level of consciousness, orientation, follow commands, response to pain and motor function. 2. Evaluations started at 6:00 am on 07/19/22 and scheduled to discontinue after 5:30 am on 07/21/22 per the instructions to evaluate every 15 minutes for the first 2 hours, every 30 minutes for 2 hours, every hour for 4 hours and every 8 hours for a total of 72 hours. There were missing evaluations on 07/19/21 at 1:30 pm, 9:30 pm, 5:30 am and 9:30 pm on 07/20/22 and 5:30 am on 07/21/22; and no vitals documented for the evaluations on 07/18/22 at 6:15 am and 6:30 am. L. On 08/11/22 at 3:31 pm during interview with Licensed Practical Nurse (LPN) #1, she reported that neurochecks should be initiated when a resident falls and hits their head and when a fall is unwitnessed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. On 08/12/22 at 9:03 am during interview with the interim Administrator, she confirmed that the neurocheck for 06/30/22 was incomplete; vitals were only checked after shift change and monitoring stopped at 1:00 pm.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33768 Based on record review and interview, the facility failed to provide pain management for 1 (R #3) of 2 (R #3 and 4) residents reviewed for pain by: 1. Not providing available PRN (as needed) pain medication even though numerous progress notes and interviews identified resident was in constant pain throughout her stay. 2. Delaying in sending resident to hospital and providing pain medication following an unwitnessed fall for over 12 hours despite immediate identification that resident was in pain. This deficient practice likely resulted in R #3 experiencing pain without appropriate relief. The findings are: A. Record review of R #3's face sheet revealed she was admitted to the facility on [DATE] with the following diagnosis (not all inclusive): pulmonary embolism (arteries in the lung become blocked), muscle weakness, idiopathic epilepsy (seizure disorder) and epileptic syndromes with seizures (sudden uncontrolled electrical disturbance in the brain), osteoarthritis (wearing down of protective tissue at end soft bones), fracture of sacrum (triangular bone below lumbar vertebrae), rheumatoid arthritis (chronic inflammatory disease) and dementia (impairment of brain function). B. On 08/11/22 at 11:28 am during interview with R #3's daughter she stated, My mother suffered neglect at [Name of facility]. They [staff] said she wasn't in pain when she had pain from a sacral fracture. I never saw her move herself at all. She was in pain and unable to mover herself. The therapist said she couldn't touch her skin without her yelling. I couldn't even imagine her turn on her side, she would yell in pain. Anytime she would move her hips, she would be in pain. They would put her in a wheelchair but decided it was torture. R #3's daughter reported that she had to ask the doctor to increase her mother's pain medication. R #3's daughter further stated, They [facility] reported she had an unwitnessed fall. They said they weren't sure what happened and they didn't know if she had fractures. She was only assessed by nurses, not the doctor. I called the doctor and told them to take her to the ER (emergency room). C. Record review of Progress Notes revealed: 06/06/22 Satisfaction with current level of pain is UTD (Unable to be determined)/unable to be communicated. No change to current plan-pain goals met. 06/10/22: Daughter here to visit resident requesting code status to be changed to DNR (Do not resuscitate) . Comfort measures only [Name of Physician #1] notified of change in code status and family requested to speak to her, provided phone number to daughter. D. Record review of Therapy Notes revealed the following: 06/07/22: Patient displays pain with bed mobility often screaming due [to] pain. 06/07/22: Pt frequently screams with mobility (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	06/08/22: Pt (patient) demos (demonstrates) limited ROM (range of motion)/strength and moans with minimal movement. 'Wait, wait, please stop. E. Record review of progress notes for R #3 dated 06/11/22 at 3:17 pm revealed Resident was notified to have fallen around 0400 (4:00 am) this morning. Pt (patient) presents currently w/(with) non verbal c/o (complaint of) pain with any movement of hips or upper extremities. Per report, member was overdue for her infusion treatment for RA (rheumatoid arthritis). Member was started on PRN (as needed) oxycodone (medication used to help relieve moderate to severe pain) .Nurse called on call provider .provider ordered pt to go to hospital for CT/Xray s/p (status post) fall to rule out injury. F. Record review of the Physical Therapist service notes dated 06/11/22 revealed, Patient screams with movement. Patient is unable to verbally respond to questions or follow commands today. The note was signed at 12:24 pm. G. On 08/11/22 at 4:16 pm during interview with Physical Therapist (PT) #1, she stated that R #3 was in a lot of pain during therapy and she thought R #3 was offered pain medication before treatment was provided. She was very confused and very reactive. If you touch the bedding, she would scream. She was dependent for all mobility. I never saw her move on her own. When asked how R #3 could have ended up on the floor on 06/11/22 if she barely ever moved, she said, I'm not sure. Maybe it was during a transfer. H. Record review of staffing scheduled identified that CNA #4 worked the evening shift on R #3's hallway from 6:00 pm on 06/10/22 until 6:00 am on 06/11/22. I. On 08/16/22 at 3:52 pm during interview with CNA #4, he confirmed that he did not remember the resident or her fall. J. Record review of the facility self report dated 06/12/22 regarding R #3's fall on 06/11/22 revealed found lying on floor next to bed head at foot on r (right) side of bed and r side awake and yelling if touch anywhere including hair able to move all extremities no bruises swelling or lacerations noted had small abrasion on lower jaw Assessment completed VS (vital signs) and neuros, complaints of generalized pain, resident was transferred to [name of hospital] for further evaluation. K. Record review of the Medication Administration Record for 05/25/22 until 06/12/22 revealed the following: 1. Pain monitoring each shift. Documented included check mark confirming it was done but did not indicate a pain scale. 2. Received scheduled Meloxicam (treat arthritis) 7.5 mg (milligrams) one time a day for pain. 3. Acetaminophen 325 mg every 4 hours prn (as needed for fever over 100 degrees) was administered on 05/26/22 at 11:40 am and 06/09/22 at 11:03 pm and documented relief as E (effective) 4. Oxycodone (pain reliever) 5 mg (ordered 06/10/22) was administered once on 06/11/22 at 12:16 am and documented relief as E 5. No other pain medication was available or administered during R #3's stay. (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Few	L. Record review of the hospital history and Physical dated 06/12/22 at 5:51 am revealed Per EMS report to ED, the patient fell ,d+[DATE] and brought to ED after she screamed all night.There was scant documentation of what actually happened before and after the fall. He reported the fall happened the morning of 06/11/22 . When asked where she is in pain she says all over. Report also identified Chronic Pain, Patient received Remicade infusions (used for Arthritis pain) every 8 weeks Patient 05/20 (2022) dose was canceled because her hospitalization , patient is now 3 weeks overdue. Per [Name of R #3's daughter], pt shows she's in pain by recoiling from touch, will curl her wrists close to her and yell if anyone touches her. M. On 08/12/22 at 11:34 am during interview with the Director of Nursing (DON), he reviewed R #3's medical record including the Medication Administration Record and confirmed that he was not seeing that R #3's pain was being monitored and appropriately treated. N. On 08/18/22 at 10:15 am during interview with Physician #1, she reported that she remembers R #3 being in pain and she never saw her move due to all assessments were conducted while resident was in bed. Physician #1 didn't remember the circumstances in which she ordered the Oxycodone on 06/10/22.