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	07/23/2024

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview the facility failed to keep residents free from abuse for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for abuse and neglect. This deficient practice likely resulted in staff to resident abuse in which R #1 had bruises to both hands. The findings are: A. Record review of R #1's face sheet, dated 07/23/24, revealed R #1 was admitted to the facility on [DATE] with multiple diagnoses including: -Type 2 diabetes mellitus (a chronic condition in which the body does nor properly process blood sugar) with foot ulcer (a wound of the foot). -Chronic respiratory failure (a chronic condition of the lungs) with hypoxia (low blood oxygen level). -Adjustment disorder (a mental health condition in which a person has difficulty adjusting to changes) with mixed anxiety (nervousness) and depressed mood (chronic sadness). -Chronic systolic heart failure (a chronic failure of the heart to adequately pump blood). B. Record review of R #1 daily nurses progress notes revealed a note, dated 06/25/24 and signed by Licensed Practical Nurse (LPN) #1, staff asked R #1 if they could see his cell phone, and he refused to let the nurse see his cell phone. The nurse thought it was hers, because the nurse and the resident had the same case and the same phone. The nurse took the cell phone from R #1's hand. R #1 had two bruises on his hand near his thumbs. (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	C. On 07/23/24 at 10:49 am during interview with LPN #1, she stated she worked as the assigned nurse in the 500 unit on 06/25/24. She stated that on 6/25/24, the facility Wound Care Nurse (WCN) came to her at the nurses station and asked for help to find her cell phone. LPN #1 stated they began to look together, and when they entered the dining area the WCN noted R #1 sat at a dining table with his cell phone. LPN #1 stated the WCN walked up to R #1 and asked to see his phone. She stated the WCN grabbed at the phone when the resident refused to give her his phone. LPN #1 stated the WCN began to wrestle with R #1 to take the phone from his hand. She stated the WCN forced the phone from R #1's hands and began to walk away. LPN #1 stated the WCN recognized the phone was not hers, she returned the phone to R #1, and she apologized to the resident. LPN #1 stated she checked R #1's hands and noted he had a finger size bruise at the base of the thumb on both hands. D. On 07/23/24 at 11:18 am during interview with Assistant Director of Nursing (ADON), he stated he passed through the dining area of the facility on 06/25/24, and he saw the WCN and R #1 arguing over a phone. The ADON stated he saw the WCN grab R #1's cell phone and pull it from R #1's hands. He stated the WCN forcefully pulled the phone away from the resident and walked away. The ADON stated the interaction was loud and obvious to all present in the area. The ADON stated R #1 was very upset by the incident. The ADON stated he felt the interaction was very inappropriate on the part of the WCN E. On 07/23/24 at 11:45 am during interview with R #1, he stated he sat at a dining table in the dining area on 06/25/24 . He stated a nurse came up behind him, reached over his shoulder, and grabbed his cell phone. R #1 stated he did not know the nurse but saw her in the facility before. R #1 stated he refused to give the nurse his phone, and they struggled. R #1 stated she forcefully pulled the cell phone out of his hands and walked away. R #1 stated he was very upset by the incident, and he had bruises on both hands caused by the nurse during the incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Potential for minimal harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39509 Based on observation, record review, and interview, the facility failed to document the daily temperature of a resident refrigerator used to store resident snacks that was located in the 100 unit of the facility. This deficient practice is likely to affect all 23 residents of the 100 unit as listed on the resident census list provided by the administrator on 07/23/24 and could likely lead to foods not being stored properly. The findings are: A. On 07/23/24 at 8:30 am during observation of the facility 100 unit, a refrigerator was in the dining area. The refrigerator contained food items and snacks for residents of the 100 unit. On the front of the refrigerator was a written log that contained daily temperatures of the refrigerator. B. Record review of this 100 unit refrigerator temperature log, dated July 2024, revealed staff did not document the refrigerator's temperature on 07/05/24 through 07/07/24 and 07/13/24 through 07/23/24. C. On 07/23/24 at 9:00 AM during an interview with Certified Nursing Assistant (CNA) #1, she verified that the refrigerator contained resident snacks and foods. She stated staff were expected to monitor the refrigerator temperature and recorded it on the temperature log. CNA #1 confirmed staff did not record the refrigerator temperature on 07/05/24 to 07/07/24 and from 07/13/24 to 07/23/24.