

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2025
NAME OF PROVIDER OR SUPPLIER  Sandia Ridge Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39509</p> <p>Based on record review and interview the facility failed to protect 1 (R #2) of 1 (R #2) resident reviewed from the use of a physical restraint that was not required to treat a resident's medical condition.</p> <p>This deficient practice could likely result in resident feeling trapped and hopeless.</p> <p>The findings are:</p> <p>A. Record review of R #2's face sheet dated 03/26/25 revealed R #2 was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Dementia (a chronic progressive decline of mental abilities and memory).</li> <li>-Need for assistance with personal care.</li> <li>-History of Traumatic Brain Injury (an injury of the brain that may cause a decline in memory, thought, personality or motor skill).</li> <li>-Homelessness</li> </ul> <p>The face sheet further revealed R #2 was discharged on [DATE].</p> <p>B. Record review of R #2's Elopement (to leave or exit without permission or knowledge of staff) Risk Evaluation dated 02/17/25 revealed he was not a risk of elopement.</p> <p>C. Record review of R #2's daily care note dated 02/27/25, stated R #2 was found in the parking lot and was brought back in by staff. A Wander Guard was being placed on his wheelchair. R #2 stated he is going to leave and doesn't want to be here</p> <p>D. Record review of the provider order dated 03/12/25 revealed an order for staff to place a Wander Guard elopement device due to poor safety awareness.</p> <p>E. Record review of R #2 care plan reviewed on 03/26/25 revealed the care plan did not contain any documentation for risk of elopement or the use of a Wander Guard.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>F. On 03/25/25 at 12:15 PM during interview with the Assistant Director of Nursing, he stated he could recall that R #2 had a Wander Guard placed on him starting in February. He reviewed and confirmed the daily care note dated 02/27/25 and agreed that a Wander Guard had been placed on R #2 at that time. ADON confirmed that he could remember R #2 had a Wander Guard on his person or on his wheelchair beginning in February 2025. He could not explain who placed the Wander Guard on R #2 and he confirmed that the order for placement of a Wander Guard was not entered until 03/12/25. ADON stated all the nurses have access to Wander Guards and a nurse would be able to place a Wander Guard any time with or without a provider order.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39509</p> <p>Based on record review and interview the facility failed to revise the care plan for 1 (R #2) of 1 (R #2) resident reviewed for care planning.</p> <p>This deficient practice has the potential for staff to fail to identify resident as an elopement risk.</p> <p>The findings are:</p> <p>A. Record review of R #2's face sheet dated 03/26/25 revealed R #2 was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Dementia (a chronic progressive decline of mental abilities and memory).</li> <li>-Need for assistance with personal care.</li> <li>-History of Traumatic Brain Injury (an injury of the brain that may cause a decline in memory, thought, personality or motor skill).</li> <li>-Homelessness</li> </ul> <p>The face sheet further revealed R #2 was discharged on [DATE].</p> <p>B. Record review of R #2's provider order dated 03/12/25 revealed an order for staff to place a Wander Guard elopement device due to poor safety awareness.</p> <p>C. Record review of R #2 care plan reviewed on 03/26/25 , revealed the care plan did not contain any documentation to include the risk of elopement and the order to place and use a Wander Guard on the resident.</p> <p>D. On 03/26/25 at 12:10 PM during interview with Assistant Director of Nursing, he confirmed R #2 had no care plan for being an elopement risk and no care plan for the placement of a Wander Guard.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39509</p> <p>Based on record review and interview the facility failed to ensure staff provided care in accordance with professional standards of practice for 1 (R #1) of 1 (R #1) resident. Nursing staff failed to maintain the scene of a suspicious death before calling the New Mexico Office of Medical Investigator. (OMI) (a New Mexico state agency that reviews and determines the need for investigation and autopsy when a person dies in a facility).</p> <p>This deficient practice could disturb the scene of a suspicious death so that it cannot be thoroughly assessed and reviewed by proper authorities.</p> <p>The findings are:</p> <p>A. Record review of OMI web page (<a href="http://hsc.unm.edu/omi/about/faq/reportable.html">hsc.unm.edu/omi/about/faq/reportable.html</a>) reviewed on 03/27/25 at 11:30 am revealed the expectation to report any death suspected to be due to violence (suicidal, accidental or homicidal) and any death of a person in a nursing home should be reported to OMI.</p> <p>B. Record review of R #1 face sheet dated 03/28/25 revealed R #1 was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Fracture (break) of upper end of left Humorous (upper arm bone)</li> <li>-Anterior (front) Dislocation of Tibia (lower leg bone), Left Knee</li> <li>-Displaced Fracture of left Tibia</li> <li>-Dislocation of left Patella (knee bone)</li> <li>-Fracture of Left Clavicle (collar bone)</li> <li>-Aortic (large artery carrying blood from the heart) Aneurysm (weak spot in an artery)</li> </ul> <p>The face sheet further revealed R #1 had been discharged from the facility on 03/18/25 at 5:02 am for other reasons.</p> <p>C. Record review of R #1's daily care note dated 03/18/25 at 9:43 am revealed R #1 was found in his room at 4:50 am with a bag over his head and tied at the neck. The nurse observed no signs of life and asked for help. At 5:00 am the bag was removed from his head and R #1 was pronounced dead. The nurse notified the health provider, facility administrator, director of nursing, and supervisor of the incident. R #1's sister was contacted and message left. At 5:20 am the nurse notified the Office of Medical Investigator. At 5:45 am R #1's body was moved, cleaned and his Foley Catheter (a tube placed into the bladder to allow free flow of urine) was removed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D. Record review of the local police report number 250021249 dated 03/18/25 revealed police were called and arrived at the facility at 5:43 am. Upon arrival the officer found R #1 in his room where R #1 was covered with a line cloth sheet from head to toe. Staff reported they had removed the plastic bag and string from R #1 and thrown it away, they had washed, cleaned the body, and changed sheets prior to police or OMI arrival. The report further revealed that the arriving officer called and informed OMI of the death of R #1.</p> <p>E. On 03/27/25 at 12:10 PM, during interview with the facility Assistant Director of Nursing (ADON), he stated the expectation is that nurses would contact OMI before moving or disturbing the body. He confirmed that in this case, the nurses did not act according to expectations and the nurses should have waited for OMI or the police to release the body of R #1 before they moved and cleaned him.</p> <p>F. On 03/31/25 at 11:15 am ,during interview, the OMI investigator stated the facility did contact the OMI office to report the death of R #1. OMI investigator stated that the nurse was told to leave the scene untouched and contact the police immediately. OMI investigator stated he was called later by police at about 6:00 am. OMI investigator arrived at the facility about 6:30 am.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39509</p> <p>Based on observation record review and interview, the facility failed to provide adequate supervision for 1 (R #2) of 1 (R #2) resident reviewed who were identified as a risk for elopement (leave facility without authorization or supervision potentially endangering themselves or others.)</p> <p>This deficient practice likely resulted in the resident being able to eloped from the facility for over 24 hours likely putting himself at serious risk of adverse outcomes.</p> <p>The findings are:</p> <p>A. On 03/26/25 at 11:00 am, during observation of the facility entrance the front door was locked. To enter the building required a doorbell be pushed and staff within the facility would then activate and unlock the door. Once inside the building there was a lounge area with a nurses station directly across from the entrance. There were chairs and multiple residents sitting in the area. Multiple staff sat at the nurses station. Staff, visitors and residents were further observed to walk up to the front door where they pushed a green button that unlocked the front door allowing them to exit the building.</p> <p>B. Record review of R #2's face sheet dated 03/26/25 revealed R #2 was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Dementia (a chronic progressive decline of mental abilities and memory).</li> <li>-Need for assistance with personal care.</li> <li>-History of Traumatic Brain Injury (an injury of the brain that may cause a decline in memory, thought, personality or motor skill).</li> <li>-Homelessness</li> </ul> <p>C. Record review of Elopement Risk assessment for R #2 revealed the following:</p> <ol style="list-style-type: none"> <li>1. 11/13/24 was not identify R #2 as an elopement risk.</li> <li>2. 02/17/25 was not identify R #2 as an elopement risk.</li> </ol> <p>D. Record review of R #2 care plan revealed the following:</p> <ul style="list-style-type: none"> <li>-11/29/24 Impaired/decline in cognitive function or impaired thought. Observe and evaluate types of changes in cognitive status-confusion, orientation, forgetfulness, decision making, impulsivity.</li> <li>-The care plan did not include a plan regarding elopement risk (to leave or exit without permission or knowledge of staff) and the placement and use of a Wander Guard or requirement for increased supervision.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>E. Record review of R #2's provider order dated 03/12/25, revealed an order for staff to place a Wander Guard elopement device due to R #2's poor safety awareness. There was no previous provider order that had been entered for a Wander Guard to be placed on R #2</p> <p>F. Record review of R #2's daily nursing notes revealed the following:</p> <p>-02/27/25 2:23 pm, R #2 was found in the parking lot and brought back in the facility by staff. A Wander Guard is being placed on his wheelchair. R #2 stated he is going to leave and doesn't want to be here. He stated he wants to go back to the streets to do his drugs.</p> <p>-02/27/25 2:34 pm, R #2 refused to have a Wander Guard on his person and on his wheelchair.</p> <p>-02/27/25 3:59 pm, R #2 seen by unit manager and the Director of Nursing seeking to leave the facility without permission and seeking for drugs.</p> <p>-03/24/25 11:00 pm, R #2 approached the nurses station where the provider sat and stated to the provider that he wanted to get out. Provider informed resident he should remain in the facility and continue care . Assistant Director of Nursing (ADON) was aware of R #2's desire to discharge and leave the facility.</p> <p>-03/24/25 11:26 pm, resident is missing in the room and dining. Nurse announced all staff to assemble at nursing station. Staff divided and checked into each room and toilet in all units. Checked all backyards and around the building. Resident not found. Staff called 911 (emergency services). Police enter resident as a missing person.</p> <p>G. On 03/25/25 at 8:15 PM during phone interview with ADON, he described R #2 as a man who was wheelchair bound who was alert and oriented but due to his traumatic brain injury he was impulsive and made poor choices. ADON stated that on 03/24/25 at 5:15 PM, he was notified that R #2 was missing and could not be found. ADON stated R #2 probably left late afternoon (due to staff were unsure when he was last seen following lunch and was not around for the dinner meal) on 03/24/25, and he had been gone for 24 hours at this time and had not been located.</p> <p>H. On 03/26/25 at 12:00 PM, during interview with ADON, he stated R #2 had been located and had been taken to the hospital. ADON stated he had met with and interviewed R #2 since being found. ADON stated R #2 had informed him that he cut his Wander Guard off and left it somewhere unknown. R #2 had then exited the building at the front door by pressing the button that unlocked the door and exited. ADON stated the Wander Guards activate an alarm as they approach the front door. He stated the alarm was loud and would alert staff that a resident wearing a Wander Guard was near the front door. ADON stated this did not happen when R #2 left because he had cut his alarm off prior to approaching the door. ADON further stated that all residents with a Wander Guard are checked daily to assure that the Wander Guard was properly placed and functioning. He further stated that staff was aware that R #2 was an elopement risk, R #2 had cut her wander guard off before, and that he required close observation and monitoring. He also stated R #2 had a habit of sitting in the front area next to the nurses station throughout the day and evening hours and that he had told several staff that he wanted to leave the building and return to the streets.</p>		