

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/02/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interviews, the facility failed to ensure the environment was free of accident hazards for 1 (R #1) of 1 (R #1) residents, when the facility staff failed to: Use a Hoyer lift (equipment used to move residents who have limited mobility) and two staff members to safely transfer R #1 as required. This deficient practice is likely to result in residents getting injured in avoidable accidents and putting residents at risk of serious injury and harm. The findings are: A. Record review of R #1's face sheet revealed an admission date of 02/23/22 with following diagnoses: Cerebral infarction with stenosis or left cerebral artery (stroke caused by narrowing (stenosis) leading to reduced blood flow and tissue death). Fracture of lumbosacral (the lower spine where the lumbar spine meets the sacrum) spine and pelvis. Failure to thrive (progressive decline marked by weight loss, poor nutrition, decreased activity, and often cognitive or emotional impairment). Rheumatoid Arthritis (chronic autoimmune disease that primarily affects the joints, causing pain, swelling, and stiffness). B. Record review of R #1's electronic health record (EHR) revealed R #1 was receiving hospice services since 05/12/22. C. Record review of R #1's physician orders, dated 04/02/25, revealed R #1 requires a Hoyer lift with two staff members for transfers out of bed. D. Record review of R #1's Kardex (documentation system that enables nurses to write, organize, and easily reference key patient information), dated 06/02/26, revealed the following: R #1 requires two-staff assistance when transferring with a total lift divided-leg sling (a patient transfer sling designed for safe lifting, with a split-leg design for comfort, support, and toileting access, compatible with most patient lifts). R #1 must be transferred by two staff using the Hoyer lift for safety and comfort. E. Record review of R #1's care plan, dated 03/26/26, revealed the following: R #1 requires one-staff assistance for activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). R #1 requires two-staff assistance for transfers using a Hoyer lift with a divided-leg sling. F. Record review of R #1's nursing progress notes, dated 04/23/26, revealed R #1 obtained a skin tear (a type of injury where the skin is torn from the body) while staff were showering R #1. G. Record review of R #1's nursing progress notes, dated 04/24/26, revealed a flat purple discoloration on R #1's chest and both forearms (the part of a person's arm extending from the elbow to the wrist or the fingertips), along with a skin tear to R #1's right forearm. H. Record review of R #1's wound and skin assessment notes, dated 04/24/26, revealed the following wounds were identified for R #1: New skin tear acquired on 04/23/26 to R #1's right forearm. The skin tear length is 1.11 centimeters (cm), width is 1.41 cm, and the depth is 0.1 cm. New skin issue with bruising to R #1's chest. The bruising length is 3.43 cm, the width is 3.6 cm, and the depth is 0 cm. New skin Issue with bruising to R #1's left forearm. The bruising length is 1.02 cm, the width is 1.02 cm, and the depth is 0 cm. New skin Issue with bruising to R #1's right forearm. The bruising length is 4.83 cm, the width is 4.19 cm, and the depth is 0 cm. I. Record review of R #1's nursing progress notes, dated 04/24/26, revealed R #1 was found to have skin discoloration to the upper chest area and both arms. The Medical Director (MD) visualized R #1's skin and determined R #1 has senile purpura (a skin condition characterized by recurrent purple bruises on sun-exposed areas, primarily the forearms and hands, due to fragile blood vessels in aging skin). J. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/02/26 at 11:30 am, during an interview, the Administrator stated R #1's bruising and skin tear was brought to her attention on 04/24/26. She stated R #1 was showered on 04/23/26 by the facility staff. The Administrator stated a Hoyer lift is used to transfer R #1 with the appropriate sling. K. On 06/02/26 at 11:50 am, during an interview, Certified Nursing Assistant (CNA) #4 stated she gave R #1 a shower on 04/23/26. She stated that she and another CNA brought the shower chair into R #1's room and transferred R #1 into the shower chair. She stated R #1 sustained a skin tear to her right forearm at some point during the shower. CNA #4 stated she reported the skin tear to the nurse right away. CNA #4 stated after R #1's shower, they transferred R #1 back to bed without using the Hoyer lift because R #1 was not heavy. CNA #4 stated she lifted R #1 under the arms (arm pits) while the other CNA moved R #1's feet, and together they lifted her from the shower chair. L. On 06/02/26 at 1:45 pm, during an interview, the Director of Nursing (DON) stated she found out about R #1's bruising on 04/24/26 when the hospice CNA was upset and alleged the facility was abusing R #1. She stated she observed purple discoloration on R #1's chest and arms, along with a skin tear. She stated staff should have used a Hoyer lift when transferring R #1. She stated she was not aware that CNA #4 and another CNA transferred R #1 without using a Hoyer lift. The DON stated transferring a resident by the underarms could have caused some of the bruising and discoloration observed on R #1, and that should not have happened.		