

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  04/12/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>47899</p> <p>Based on observation and interview, the facility failed to treat residents with respect and dignity for 2 (R #22 and R #74) of 2 (R #22 and R #74) residents randomly identified when the facility failed to ensure staff knocked on the resident's bedroom door before they entered the resident's room. These deficient practices could likely result in residents feeling unimportant and they did not have privacy. The findings are:</p> <p>Findings for R # 22</p> <p>A. On 04/08/24 at 10:57 am, during an observation, Certified Nursing Assistant (CNA) #1 walked into R #22's room to answer the call light without knocking on the resident's door before entering.</p> <p>B. On 04/08/24 at 11:00 am, during an observation, CNA #1 walked into R #22's room without knocking on the door before entering.</p> <p>C. On 04/08/24 at 11:01 am, during an interview with CNA #1, she confirmed she should have knocked on R #22's door prior to entry.</p> <p>Findings for R # 74</p> <p>D. On 04/08/24 at 2:30 pm, during an observation, Registered Nurse (RN) #1 walked into R #74's room without knocking on the door before entering.</p> <p>E. On 04/08/24 at 2:30 pm, during an interview with R #74, she stated staff did not knock on her door before they entered. She stated the staff just walked into her room. R #74 stated she did not like that staff did not treat it like it was her room. the resident said, It bothers me.</p> <p>F. On 04/08/24 at 2:35 pm, during an interview, RN #1 confirmed staff should knock on the door and wait until the resident gave permission to come into the room.</p> <p>G. On 04//11/24 at 2:36 pm, during an interview with the Director of Nursing (DON), she stated staff entering a resident's room are expected to knock on the door, announce they want to come into the resident's room, and wait for permission. They should not just walk into the resident's room.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>35632</p> <p>Based on record review and interview, the facility failed to ensure residents were bathed according to their preference for 1 (R #83) of 3 (R #83) resident reviewed for showers. This deficient practice has the potential to prevent residents from maintaining personal hygiene per their personal preference. The findings are:</p> <p>Resident #83</p> <p>A. On 04/08/24 at 8:43 am, during an interview with R #83, she stated she wanted to shower everyday. She stated she was independent and could shower on her own. The resident stated she did not understand why she could not shower when she wanted. She stated she took a shower three days per week now. R #83 also stated that showering should be to her preference, not the facility's schedule, or when they had a staff member available. R #83 stated she was aware the facility policy was to have staff present for all residents when showering.</p> <p>B. Record review of R # 83's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 01/03/24, indicated the following:</p> <ul style="list-style-type: none"> <li>- R #83 was independent with showering and bathing.</li> <li>- R #83 had a Brief Interview of Mental Status (BIMS, a screening for cognitive impairment) score of 15, intact cognition.</li> </ul> <p>C. Record review of R #83's care plan, last updated on 01/10/24, indicated R #83 required minimal assistance for activities of daily living (ADL) in bathing, transfer, and toileting.</p> <p>D. On 04/08/24 at 10:45 am, during an interview with Registered Nurse (RN) #3, she stated the residents usually got showers in the morning. RN #3 stated they will ask R #83 if she wanted a shower, and she refused. She stated the resident will come back later, like at 4:30 pm, and ask if she can have shower. RN #3 stated that was not the best time for the staff to give showers, and the staff often were not able to accommodate her. The RN stated R #83 did not want to take a shower in the morning. She said last week the resident asked to take a shower at 4:30 pm, and when the staff refused the resident reported it to Social Services. RN #3 stated the facility policy was that resident could not shower alone, and staff must be present. She stated R #83 might be able to shower independently, but the facility's policy did not allow it</p> <p>E. On 04/10/24 at 2:08 pm, during an interview with the Director of Nursing (DON), she stated R #83 wanted to take a shower when she wanted to shower, and it was usually not at the best time for staff. She stated R #83 was a little impulsive and would sometimes make decisions that were not in her best interest. The DON stated she felt the resident needed to have a least someone in the room while she showered. The DON stated she implemented a facility policy that no one showered completely independently. She stated that if R #83 worked with them a little bit then she probably could get a shower everyday. The DON stated the resident refused to do that.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35632</p> <p>Based on record review and interview the facility staff failed to report an incident to the state agency in which staff found a resident unresponsive for 1 (R #115) of 1 (R #115) resident sampled for accidents. If the facility fails to report injuries of unknown origins to the state agency, it could likely impact the safety of the residents. The findings are:</p> <p>A. Record review of the nursing progress notes for R #115, dated 03/20/24 at 7:47 am, indicated staff observed R #115 outside in a wheelchair, slumped forward and non-responsive, with burnt foil, two straws and a lighter at his feet on 04/19.24. The staff brought R #115 to his room, emergency medical services (EMS) were activated, staff gave the resident two Narcan intramuscular (used to stop the effects of opioids), physician in room, and the resident began to respond. EMS arrived. Resident refused transport to emergency room (ER). Resident kept at nurse's side, and the resident stated he wanted to go to the ER. When EMS arrived the resident refused again. Care plan updated to address possible substance abuse. Drug screen and supervised outings until results.</p> <p>B. Record review of the drug screen for R #115, completed on 03/19/24, indicated R #115 did not have any illegal drugs in his system.</p> <p>C. On 04/10/24 at 2:30 pm, during an interview with the Administrator, he stated he did not report this incident to the state agency, because it was not a drug overdose. He said the physician was present, they gave the resident two doses of Narcan, the resident responded to it, and his vitals normalized. The Administrator stated the resident passed a drug screen, stated he did not use drugs, and refused to go to the hospital with EMS. The Administrator stated there was not anything to report.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47899</p> <p>Based on record review and interview, the facility failed to develop a comprehensive, person-centered care plan which included information about current dialysis strategies used for 1 (R #39) of 1 (R #39) residents reviewed for care plans. This deficient practice could likely result in residents not receiving the care needed to reach their highest practicable level of well-being. The findings are:</p> <p>Findings for R #39</p> <p>A. Record review of R #39's Face Sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: End stage renal disease (a condition where the kidney reaches advanced state of loss of function. This causes changes in urination, fatigue, swelling of feet, high blood pressure, and loss of appetite), dependence on renal dialysis (kidney dialysis is the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally), and hypertension (high blood pressure)</p> <p>B. Record review of R #39's care plan, dated 02/12/24, revealed the care plan did not address the following:</p> <ul style="list-style-type: none"> <li>- The dialysis fistula (made by joining an artery and a vein in the arm),</li> <li>- Care bruit (a rumbling or swooshing sound that you can hear or feel at the site of your hemodialysis access),</li> <li>- Thrill [a vibration felt upon palpation (touch)],</li> <li>- Monitoring for signs and symptoms of infections (redness, pus coming out the dialysis site, sore to the touch),</li> <li>- Bleeding and anything abnormal regarding the site,</li> <li>- Goals,</li> <li>- Interventions.</li> </ul> <p>C. On 04/11/24 at 2:43 pm, during an interview with the Director of Nursing (DON) confirmed there was nothing in the care plan that centered around dialysis. The DON's expectations were that the care plan would include all things dialysis.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>35632</p> <p>Based on record review and interview, the facility failed to ensure residents or their representatives were invited to care plan meetings for 1 (R #48) of 1 (R #48) resident reviewed for participation in care planning. If residents are not able to participate in their care plan development, then residents could likely not receive the care and treatment that they need or want. The findings are:</p> <p>R #48</p> <p>A. Record review of the progress notes for R #48, dated 01/01/24 to 04/09/24, revealed staff did not document a care conference or an invitation to a care plan meeting in the last three months.</p> <p>B. On 04/09/24 at 9:39 am, during an interview with R #48, he stated he used to go to his care plan conferences, but now he was not invited.</p> <p>47899</p> <p>R # 78</p> <p>C. Record review of medical records for R #78 indicated staff did not document a care conference or an invitation to a care plan meeting in the last three months.</p> <p>D. On 04/09/24 at 9:21 am, during an interview with R #78, she stated she was not aware of the care plan meetings, because the staff did not invite her. She stated she did not know there was anything available like that. The resident stated she would like to attend them.</p> <p>E. On 04/11/24 at 11:50 am during an interview with the Administrator, he stated the care plan meetings and conferences did not get done like they were supposed to. He stated staff did not send out notifications, because there were not care plans scheduled.</p> <p>F. On 04/11/24 at 3:00 pm, during an interview with the Social Services Assistant (SSA), she stated staff notified the residents of the care plan meetings by laying a letter on their bed. She was unsure if the staff kept copies of the letters. The SSA stated staff verbally invited R #78 to the care plan meeting because it was easier just to tell the resident.</p> <p>G. On 04/11/24 at 11:46 am and 04/12/24 at 9:04 am, during an interview with the Social Services Director (SSD), she stated she has been behind on care plans, because she did not have help. She stated the care plan meeting notifications were not going out, because the care plans were not done. The SSD stated R #78's care plan meetings in the past have just been a verbal invite, and she did not keep a sign in sheet for the care plan meeting.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40671</p> <p>Based on record review and interview, the facility failed to ensure residents or their representatives were aware of and understood the risks and benefits of the psychotropic medication they received for 1 (R #44) of 3 (R #'s 44, 88 and 90) residents when staff did not inform residents or their representatives of why a medication was prescribed and administered, what diagnoses or condition it treated, what side effects could occur, and alternative medication or nonpharmacological approaches. This deficient practice could likely result in residents potentially receiving unnecessary treatment or medication. The findings are:</p> <p>A. Record review of the Face Sheet for R #44 revealed an initial admitted [DATE] and included the following diagnoses: Dementia (a group of symptoms that affect memory, thinking and interfere with daily life) with behaviors, major depressive disorder (a persistent feeling of sadness and loss of interest), and anxiety disorder (intense, excessive and persistent worry and fear about everyday situations).</p> <p>B. Record review of the Physician's Orders for R #44 revealed the following:</p> <p>- Buspirone HCl (a psychotropic medication that affects chemicals in the brain and is used to treat anxiety) tablet, 5 mg. Give one tablet by mouth three times a day for anxiety/behaviors. Start date: 02/15/22.</p> <p>C. Record review of the Psychotherapeutic Medication (drugs that alter mood, perceptions, and behaviors and are used to treat mental disorders) Administration Disclosure form for R #44, dated 10/11/21, revealed the form did not identify buspirone as a medication for which the staff provided the resident or the resident's representative information or for which the resident or resident representative gave consent.</p> <p>D. Record review of the electronic medical record for R #44's revealed the record did not contain documentation staff informed R #44 or the responsible party on the risks and benefits of why buspirone HCl, order dated 02/15/22, was prescribed and administered, what diagnoses or condition it treated, what side effects could occur, and alternative medication or nonpharmacological approaches buspirone that was prescribed on 02/15/22.</p> <p>E. On 04/12/24 at 1:25 pm during an interview with the DON, she stated there should be a signed consent form for the use of buspirone and verified there was not one on file for R #44. She stated the Psychotherapeutic Medication Administration Disclosure consent form in R #44's file was for the psychotropic medications that R #44 took since 2021. She stated when the buspirone was later prescribed there should have been a new consent signed to include all current psychotropic medications.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47899</p> <p>Based on observation and interviews that facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure medications were kept in original packaging.</li> <li>2. Ensure all expired supplies were not kept with unexpired supplies.</li> <li>3. Ensure medication refrigerator temperatures were recorded.</li> <li>4. Ensure refrigerator temperatures for vaccine refrigerator were recorded.</li> <li>5. Ensure expired medications were not kept with unexpired medication.</li> </ol> <p>These deficient practices are likely to result in all 125 residents identified on the census list provided by the Executive Director (ED) on 04/08/24, medications that were not kept in the original package were continued to be accessed, to receive expired medications or supplies that have lost either their potency, or effectiveness, to receive medication or vaccines that should have been kept at correct temperature have lost either their potency or effectiveness. The findings are:</p> <p>Ensure medication were kept in original packaging.</p> <p>A. On 04/08/24 at 8:17 am, during an observation of 300 medication cart, a small medication cup was full of round pills. The round pills were not in the original packaging and did not have an identification label on the cup.</p> <p>B. On 04/08/24 at 8:17 am, during an interview, the Certified Medication Aide (CMA) #1 confirmed the small medication cup of pills. He stated the pills were Tylenol 325 milligram (MG). The CMA stated the pills were taken out of the original container and placed in the small cup for staff's convenience.</p> <p>C. On 04/12/24 at 1:48 pm, during an interview, the Director of Nursing (DON) confirmed staff should not take medication out of the original container and store in the top of the medication cart.</p> <p>Ensure all expired supplies were not kept with unexpired supplies.</p> <p>D. On 04/08/24 at 8:34 pm, observation of medication room revealed the following expired supplies:</p> <ol style="list-style-type: none"> <li>1. Four boxes of lubricating jelly expired on 04/2023.</li> <li>2. Eight bottles of Ultrasound gel expired on 08/27/23.</li> <li>3. Thirteen BD safely glide (syringe that is designed to ensure protection from neelesticks)1 milliliter (ML) syringe expired on 07/31/2023.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>4. Nineteen BD safety glide 1 ML syringe expired on 04/30/2023.</p> <p>5. Five intravenous (IV) start kits expired on 05/11/2022.</p> <p>6. Six IV start kits expired on 11/30/2023.</p> <p>7. Five Central line tray (a long, flexible tube inserted into ta vein that leads directly to the heart) Choraprep (is apowerful, persistent anitmicrobial solution) expired on 05/2023.</p> <p>E. On 04/08/24 at 8:34 am, during an interview with the Director of Nursing (DON) confirmed the supplies were expired. The DON stated it was expected that one of her nursing managers to go through the supply rooms and ensure things were not expired.</p> <p>Ensure Medication temperatures were done for medication refrigerator.</p> <p>F. Record review of the medication room's refrigerator temperature logs revealed staff did not complete the temperatures as follows:</p> <ol style="list-style-type: none"> <li>1. On 04/01/24, staff did not document the temperature twice in a day.</li> <li>2. On 04/02/24, staff did not document the temperature twice in a day.</li> <li>3. On 04/03/24, staff did not document the temperature twice in a day.</li> <li>4. On 04/04/24, staff did not document the temperature twice in a day.</li> <li>5. On 04/05/24, staff did not document the temperature.</li> <li>6. On 04/06/24, staff did not document the temperature.</li> <li>7. On 04/07/24, staff did not document the temperature.</li> </ol> <p>G. On 04/08/24 at 8:45, during an observation, the medication room's refrigerator contained insulin medications.</p> <p>H. On 04/08/24 at 8:36 am, during an interview, the Director of Nursing (DON) stated it was expected that staff filled out the temperature log for the medication refrigerator daily. She confirmed there were some dates missing temperatures.</p> <p>Ensure temperatures for vaccine refrigerator were done.</p> <p>I. Record review of the medication room's vaccine refrigerator temperature logs, revealed staff did not complete the temperatures as follows:</p> <ol style="list-style-type: none"> <li>1. On 04/05/24, staff did not document the temperature twice in a day.</li> <li>2. On 04/06/24, staff did not document the temperature.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. On 04/07/24, staff did not document the temperature.</p> <p>J. On 04/08/24 at 8:36 am, during an interview with the Director of Nursing (DON), she stated it was expected staff recorded the correct temperatures on the vaccine refrigerator temperature logs daily. She confirmed there were some temperatures missing.</p> <p>Ensure expired medications were not kept with unexpired medications.</p> <p>K. On 04/08/24 at 9:10 am during an observation of the 500 medication cart, R # 78's gemfibrozil (used to help lower bad cholesterol and fats), 600 milligrams (MG) tablet was in the medication cart and expired on 02/29/2024. The medication was mixed together with non-expired medication.</p> <p>L. On 04/08/24 at 9/11 am, during an interview, Registered Nurse (RN) # 1 confirmed the medication was expired and should not be in the medication cart.</p> <p>M. On 04/09/24 at 1:29 pm, during the interview, the DON stated the nursing staff should go through their medication carts. The DON said each hall had a CMA that went through the medication carts at least once a month and looked for expired medications.</p>		