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	01/13/2023

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40417 Based on interviews, record review, and review of facility policy, the facility failed to immediately notify/report to the physician a change of condition for two residents (Resident (R)75 and R53) out of 28 sampled residents. The facility's failed practice likely resulted in R75's death at the facility on [DATE]. Findings include: Review of facility-provided policy titled Change of Condition, [DATE], revealed .A Center must immediately inform .the patient's physician a significant change in patient's physical mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status) in either life-threatening conditions or clinical complications .to provide appropriate and timely information relevant to the patient's condition . 1. Review of R75's undated ADMISSION RECORD, located in the Electronic Medical Record (EMR) revealed R75 was initially admitted to the facility on [DATE], readmitted on [DATE] and discharged (expired) on [DATE] with multiple diagnosis to include type 2 diabetes, acquired absence of left above the knee, dementia, and delusional (firmly held beliefs not set in reality) disorder. Review of R75's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], located in her EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) was not conducted and indicated R75 was severely cognitively impaired. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of R75's Progress Note under the Notes tab in the EMR, revealed the following: [DATE] at 8:33 PM . Note: This writer received report from . [Licensed Practical Nurse LPN 1] the night nurse, that this resident was heard moaning while asleep most of the time during the night. Sternum [sic] done by night nurse and resident was observed crying. This writer saw this resident between the hours of 0630 AM and 0700 AM. Resident was observed lying in bed in a supine position, had eyes closed and was heard making some moaning/snoring sound. Sternum rub (A sternal rub is the application of painful stimulus with the knuckles of a closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli) was done and resident (R75) partially opened her eyes. Between the hours of about 0800 AM and 0815 AM . the CNA (Certified Nursing Assistant 4) called this writer to resident's room that this resident was nonresponsive. Resident was in a supine position. Sternum rub done and was nonresponsive. No pulse felt. Body was warm to the touch. CPR (Cardiopulmonary Resuscitation) was started. 911 was called and came to assist. Resident was pronounced dead at 0853 AM. Resident's husband was notified and came to the facility with resident's two sons. Resident's body was picked up by [name of mortuary] at about 1314 (1:14) PM. Resident's husband and two sons picked up all resident's belongs During an interview on [DATE] at 1:19 PM, LPN3 confirmed R75 was difficult to arouse (awaken) on [DATE]. LPN3 confirmed LPN1 reported to her R75 required a sternum rub to be arouse. LPN3 confirmed she performed a sternum rub and R75's fluttered her eye lids. LPN3 confirmed she did not notify the physician of R75's change in condition. LPN3 confirmed R75 expired at the facility, over an hour later. During an interview on [DATE] at 4:55 PM, the Wound Care-Registered Nurse (WC) confirmed she would expect the nursing staff to assess R75 for her change of condition. WC confirmed difficult to arouse was considered a change in condition. WC confirmed she expected the nursing staff, who had to perform a sternum rub to arouse R75, to report R75's change in condition to her physician. WC confirmed R75 expired at the facility on [DATE]. During an interview on [DATE] at 6:38 PM, Registered Nurse (RN) 2 confirmed nurses were expected to call the resident's provider of a change of a condition. During an interview on [DATE] at 6:47 PM, the Unit Manager-Licensed Practical Nurse (UM) 1 confirmed she expected the nursing staff to call and report R75's change in condition to her (R75) physicians. UM1 confirmed R75 expired hours after the nursing staff had difficulty arousing on [DATE]. During an interview [DATE] at 9:14 AM, the facility Medical Director confirmed her expectation for the facility's clinical staff was to notify the resident's provider immediately of the change of condition of difficulty arousing R75 on [DATE]. The Medical Director confirmed her expectation for the facility's clinical staff was to assess R75 (upon the change of condition) on [DATE] not limited to but to include obtaining vital signs and checking her fingerstick blood sugar. The Medical Director stated physician's immediate notification of resident's change of condition was time sensitive and important because R75's change of condition could be life threatening and require life sustaining treatment, and omittance could cause death. The Medical Director confirmed she had reviewed R75's case with her Nurse Practitioner/Medical Doctor and had concerns R75 did not receive medical treatment because the physician's/providers were not notified of her change of condition. The Medical Director stated the facilities clinical staff had a history of not following policies and procedures. The Medical Director confirmed the facility's clinical staff not following policies and procedures was dangerous for residents. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 10:11 AM the Medical Doctor (MD) confirmed he was a provider for residents at the facility including R75. MD confirmed he expected the facility staff to inform the medical provider of a resident's change in condition within 15 minutes of the change including (difficult to arouse and sternum rubs). MD confirmed provider notification was important for the facility to receive orders from the physician for diagnostic testing and treatment for the change in condition. During an interview on [DATE] at 8:47 PM, LPN 1 confirmed she provided care for R75 on [DATE] night shift through the morning of [DATE] and reported off to LPN3. LPN1 confirmed she did not notify R75's physician of her difficulty to arouse. 25490 Findings for R53 2. Review of R53's Admission Record, located in the EMR under the Profile tab, revealed an admitted [DATE] with medical diagnoses that included but not limited to diabetes and Acute Systolic Congestive Heart Failure (CHF-buildup of fluid in the lungs). CHF often results in rapid weight gain due to the retention of fluid. Review of R53's admission Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R53 was cognitively intact. Review of R53's Care Plan, located in the EMR under the Care Plan tab and dated [DATE], revealed . [R53] is at high nutrition risk d/t (due to) uncontrolled T2DM (Type 2 Diabetes Mellitus). BMI (Body Mass Index) Class III obesity range. Under Interventions indicated, weigh per protocol and alert dietitian and physician to any significant weight loss or gain. Review of a physician order of R53's diabetes medication, dated [DATE] and located in the EMR under Clinical Physician Orders, indicated NovoLog Flex Pen Subcutaneous Solution Pen-injector 100 UNIT/M (Insulin As part) revealed, Inject as per sliding scale: . 401 - 450 = 12 give 12 units and notify provider . Review of the physician order, dated [DATE] and located in the EMR under Clinical Physician Orders, indicated, change weights to 3 times a week. Call MD (Medical Director) if over 285 [pounds]. Review of R53's Blood Sugar Summary, located in the EMR under the Weights and Vitals tab dated from [DATE] until [DATE], indicated the following blood sugar readings above 401 mg/dl (milligrams/deciliter). [DATE]- 450, [DATE]-427, [DATE]-416, [DATE]-423, [DATE]-447, (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	[DATE]-402, [DATE]-435, [DATE]-440, [DATE]-439, [DATE]-419, [DATE]-419 and [DATE]-435, [DATE]-420, [DATE]-441 and [DATE]-437, [DATE]-442, [DATE]-421 and [DATE]-444, [DATE]-423, [DATE]-405, [DATE]-401 and [DATE]-403, [DATE]-432 and [DATE]-431, [DATE]-437 and [DATE]-442, [DATE]-433, [DATE]-423, and [DATE]-439, [DATE]-445, [DATE]-428, and [DATE]-441, [DATE]-435, [DATE]-415, [DATE]-450, [DATE], and [DATE]-416, [DATE]-407, and [DATE]-468. From the order date of [DATE] through [DATE], R53's blood sugars were between the range of ,d+[DATE] mg/dl thirty-nine times. The physician was not notified per order of these elevated blood sugar levels. Review of R53's Weight Summary, located in the EMR under the Weights and Vitals tab and dated from [DATE] until [DATE] indicated the following weights above 285: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	[DATE]- 285.3, [DATE]-286.1, [DATE]-285.4, [DATE]-289. [DATE]-288.6, [DATE]-290.6, [DATE]- 290.7, [DATE]-291.3, [DATE]-287.1, [DATE]-287.6, [DATE]-287.1, [DATE]-288.1, [DATE]-285.3, [DATE]-287.1, [DATE]-288.9, [DATE]-289.7, [DATE]-288.9, and [DATE]-288.8. From the order date of [DATE] until [DATE] R53's weights were 285 or over on seventeen incidents. The physician was not notified of these weights that could indicate fluid buildup. During an interview on [DATE] at 11:20 AM, Registered Nurse (RN)3 stated, The order dated [DATE] states, to change weights to 3 times per week and call MD [medical doctor] if over 285 along with an order dated on [DATE] to contact the doctor if R53's blood sugars are over 401. RN3 further stated, there were many opportunities that the doctor should have been notified but the doctor was not notified. Surveyor asked RN3 to share some complications of high blood sugar levels. RN3 stated, if the insulin becomes too high there can be complications. The resident may have confusing, acetone breath, respiratory issues, and uncontrolled blood sugar levels could lead to death. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with the Director of Nursing (DON) on [DATE] at 12:16 PM, this surveyor asked the DON what the order note written for R53 on [DATE] stated. DON stated, the order states, the doctor should be notified when R53's blood sugars are between ,d+[DATE], give 12 units and notify provider. Surveyor asked, how many opportunities were there from [DATE] until [DATE] to notify the doctor? DON stated, too many times. Surveyor asked, What is your expectation of your staff? The DON stated, it is expected that all staff always follow the doctor's order and complete a progress note. Surveyor asked DON what are complications of elevated blood sugars? The DON stated, there can be multiple areas of decline from diabetes, there is fatigue, jitteriness, sweating, skin tissue breaks down, confusion, agitation, increased behaviors, diabetic neuropathy, and vision damage. During this same interview, the DON confirmed R53's elevated blood sugars, elevated body weight, and/or changes with R53's medical condition were not reported to the doctor per orders dated [DATE] and [DATE]. During an interview with the Clinical Lead Corporate (CLC) on [DATE] at 5:25 PM revealed, the facility does not have a policy for what staff should do if a resident has a high blood sugar reading. The expectation is for the facility staff to follow doctor's orders. During an interview on [DATE] at 12:25 PM, the Administrator stated, when a change of condition is identified, it is the facility's expectation that staff notify the family, notify the physician and notify the DON and that all physicians orders are followed. On [DATE] at 6:28 PM, the Administrator, the Clinical Lead Corporate, and Director of Nursing (DON) were notified of an Immediate Jeopardy (IJ) at F580-L: Notify of Changes. The Immediate Jeopardy began on [DATE] when the nursing staff failed to notify the physician of their difficulty in arousing R75 with a sternal rub through the night and into the next day ([DATE]). In addition, the nursing staff failed to notify the physician of elevated blood sugar levels and increased weight for R53 who had diagnoses of diabetes and congestive heart failure (CHF-buildup of fluid in the lungs and extremities). The facility provided an acceptable removal plan on [DATE] at 4:29 PM. The removal plan included Licensed nurses would complete assessments on current residents residing in the center to determine presence of a medical change in condition. Identified issues were reported to the physician. Registered nurses would review resident's blood glucose and weights. Identified changes in conditions not reported to MD would be reported and medical orders would be followed, with monitoring. The Director of Nursing would educate current staff and auxiliary staff regarding the policy for resident change in condition. The survey team verified implementation of the Removal Plan. The Administrator, the Clinical Lead Corporate, and Director of Nursing (DON) were notified that the IJ at F580-L was removed on [DATE] at 7:35 PM.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25490 Based on interviews, record review, and policy review, the facility failed to ensure residents were protected from further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress and failed to have evidence that all alleged violations were thoroughly investigated for one resident (Resident (R) 25) out of one resident reviewed for abuse in a total sample of 28 residents. Specifically, the two alleged perpetrators, Certified Nursing Assistant (CNA)1 and CNA2 were not removed from the facility but were reassigned and remained in the facility working with other residents the evening of the alleged abuse and the Administrator failed to thoroughly investigate conflicting verbal and written statements by the CNAs. This deficient practice could likely result in residents being at risk of abuse. Findings include: Review of the facility investigation report revealed the facility failed to follow facility policy titled Abuse Prohibition, dated 10/24/22. The policy reads, the employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. Review of R25's Admission Record, located in the Electronic Medical Record (EMR) under the Profile tab, revealed an admitted [DATE] with medical diagnoses that included but not limited to unspecified Dementia, unspecified severity, with other behavioral disturbances. Review of R25's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 12/03/22, revealed R25's Brief Interview for Mental Status (BIMS) score of a 15 out of 15 indicating R25 was cognitively intact. During an interview on 01/09/23 at 3:16 PM, R25 stated that she was abused in the facility by two CNA's on 12/27/22 while receiving incontinent care. R25 shared a picture of a bruise on an unidentifiable location of the body. The photo was located on R25's phone. Further interview revealed on 12/27/22 during incontinent care two CNAs lowered R25's blankets to the foot of the bed to provide care. R25 stated you see these two blankets? I received them for Christmas and did not want them to be touched. I reached for them, and the CNA grabbed my arm. During an interview on 01/09/23 at 5:21 PM, the Abuse Coordinator/Administrator stated, I reported the allegation to the Department of Health, started an internal investigation to determine if substantiated or not, we removed staff members involved and started conducting our own interviews. The Administrator stated, on the following day [12/28/22] the unit manager received some information that CNA1 was involved. Their agency was immediately notified via phone and the agency replied by email. The email stated, 'Please keep us posted on her investigation. The Administrator further stated, later on, that day [12/28/22], I found out that CNA2 was also involved, and I notified the agency that CNA2 was also mentioned in this allegation. Administrator shared with the Surveyor an email correspondence from the CNA agency which stated, I have canceled all of her shifts. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with CNA1 (the CNA alleged to have held down the hands of R25) on 01/09/23 at 6:25 PM CNA1 stated, On 12/27/22, I was working with another CNA (CNA2) for the first time. We started our rounds, vitals and passing trays. The resident (R25) was pressing the call button and said, 'I need to be changed.' when we pulled down her blankets, R25 started cursing and said, 'don't touch my blanket'. We apologized and started care again. CNA1 continued to state, The resident became more aggravated again and started hitting us and I never held down the resident's hands. I only tried to block her from hitting me and we removed ourselves from the room. During this same interview CNA1 further stated that at no point did CNA1 or CNA2 hold down the hands of R25. CNA1 further stated, on the night of the incident CNA1 attempted to explain to R25's daughter what occurred and that R25's daughter pushed and shoved the CNA out of the room. Surveyor was unable to interview CNA2 due to the CNA being hospitalized . Review of CNA1 and CNA2's time sheets, provided by the facility, indicated CNA1 clocked in on 12/27/22 at 6:03 PM and clocked out on 12/28/22 at 5:59 AM. Further review of the time sheets revealed CNA2 clocked in on 12/27/22 at 5:58 PM and clocked out on 12/28/22 at 5:59 AM. The facility timesheets indicated that the CNA's were not removed from the facility per facility policies. During an interview with the facility Abuse Coordinator/Administrator on 01/10/23 at 1:47 PM, this Surveyor asked, why weren't the CNA's removed at the time of the incident? The Administrator stated, the CNA's were not immediately suspended at the time of the allegation because we were unable to identify the CNA's involved. The daughter just said the mother (R25) was being abused and that was all the information I had. The Administrator continued to state, When staff attempted to talk with the resident (R25) the resident refused to speak to staff in reference to this incident. Surveyor asked the Administrator the policy regarding an allegation of abuse. The Administrator stated, alleged perpetrators should be removed from the facility for the safety of the resident. Interview with the facility Director of Nursing (DON) on 01/10/23 at 1:52 PM revealed, at the time of the incident the alleged CNA's were not known by me. I acted off of what information I had and the reason we did not suspend anyone on that day was because I did not know who the perpetrators were until the next day. The Registered Nurse (RN) on the floor did not tell me who the perpetrators were on the evening of the incident. I found out the next day by the scheduling staff and reading the witness statements left under my door. Once we realized who the alleged perpetrators were their agency was contacted and the CNA's were suspended. Surveyor asked the DON what is the facility policy once the alleged perpetrators are identified? The DON stated, to suspend the alleged perpetrators. During this same interview, this surveyor shared the written statement by RN1 dated 12/27/22 at 8:00 PM. RN1's written statement revealed, the CNA walked into the room to explain what had happened and R25's daughter pushed her out . The DON was informed of the incident and a new aide was assigned to take care of the resident for the night. The written statement by RN1 contradicted the DON recollection of the incident which occurred on 12/27/22. Surveyor asked the DON, Was the RN on duty the night of the incident aware of the facility Abuse Policy [to remove the alleged perpetrators]? The DON stated, They should know. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 01/11/23 at 7:32 PM, RN1 stated, on the night of 12/27/22 I was passing medication on the hall. A CNA approached me after leaving R25's room and reported that the resident was very agitated. RN1 further stated, It was time for the resident's night medications, so I prepared the medications. At this same time the daughter stormed into the hall and stated, 'I got a call from my mother saying she is being abused.' RN1 stated to the daughter, 'Oh, I didn't know that I only heard she was agitated' and they proceeded to R25's room. RN1 expressed once they got to R25's room the resident shared with the RN1 and daughter that two CNA's abused her by holding down her hands. RN1 stated that while R25 was telling the daughter what had occurred, CNA1 came back into R25's room to explain their side of the incident and R25's daughter pushed the CNA out of the room. Surveyor asked RN1 how were you able to identify the alleged perpetrators. RN1 stated, there were only two CNA's working the hall that evening. Surveyor asked RN1 was the facility Administrator notified of the incident and the alleged perpetrators. RN1 stated, yes. Interview on 01/09/23 5:21 PM, the Abuse Coordinator/Administrator stated, The staff were trying to get away from the resident because the resident was pulling their hair. This surveyor shared the witness statement written by CNA2 dated 12/27/22 which stated, So, my coworker just hold her (R25) hands she wouldn't atack[sic] us, she was trying to bite us . The Administrator stated, We read the witness statements the next morning, what stood out to me was the CNA said, they held her hands. I took it as they were trying to protect themselves because the resident was being combative. English is this CNA's second language and what she said is not what is written. When asked if he investigated further the disparity between the CNA's written statement and verbal statement before concluding the abuse was unsubstantiated, the Administrator verified that he took the verbal statement as the accurate statement and did not investigate further. On 01/10/2023 at 6:40 PM, the Administrator, Director of Nursing (DON), and the Clinical Lead Corporate (CLC) were notified of the Immediate Jeopardy (IJ) at F610-L: Investigate, protect, correct Alleged Violation. The Immediate Jeopardy began on 12/27/22 when R25 and her daughter told Registered Nurse (RN)1 that CNA1 and CNA2 abused her by holding down her hands while providing incontinence care. The facility provided an acceptable removal plan on 01/11/23 at 9:39 AM. The removal plan included education to facility staff on the Abuse policy along with special training to the facility Director of Nursing and Abuse Coordinator/Administrator. The Survey team interviewed facility staff and verified that 100% of staff in the facility had received the Abuse policy training. The survey team verified all elements of the facility's IJ Removal Plan and removed the IJ on 01/11/23 at 5:35 PM.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46585 Based on observations, staff interviews, record review, and policy review, the facility failed to ensure an individualized program of activities was implemented for one of one resident (Resident (R) 38) reviewed for activities out of a total sample of 28 residents. This failure had the potential to cause boredom and isolation for R38. Findings include: Review of the facility's policy titled, Recreation Services Policies and Procedures, revised 04/01/18, documented Purpose: To create opportunities for each person to have a meaningful life by supporting his/her domains of wellness: identity, growth, autonomy, security, connectedness, meaning, and joy. To provide an ongoing person-centered recreation program that incorporates the individual's interests, hobbies, and cultural preferences which are integral to maintaining and improving a resident's physical, mental, and psychological well-being and independence. Record review of R38's undated Admission Record, located in the Profile tab of the Electronic Medical Record (EMR), revealed R38 was admitted to the facility on [DATE] with diagnoses to include paranoid schizophrenia (serious mental illness of delusions (firmly held beliefs not based in reality) and hallucinations (hearing, seeing, tasting, smelling things not there), Parkinson's disease, dementia, and depression. Record review of R38's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/22, located in the MDS tab of the EMR, revealed staff assessed R38 as feeling down, depressed, or hopeless seven or more times out of 14 days. R38 was also assessed as needing extensive assistance for all activities of daily living. R38 was assessed as having a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating she was severely cognitively impaired. Record review of R38's quarterly Care Plan, dated 10/11/22 and located in the Care Plan tab of the EMR, revealed the focus, While in the facility, [R38] states that it is important that she has the opportunity to engage in daily routines that are meaningful relative to her preferences. The interventions included: .I enjoy having reading materials, listening to music, using a computer, doing crosswords/puzzles/game, watching TV/movies. Observation on 01/10/23 at 10:20 AM revealed R38 seated in her wheelchair in the dining room alone with no stimulation. Observation on 01/10/23 at 2:02 PM revealed R38 seated in her wheelchair in the dining room alone with no stimulation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/11/23 at 10:37 AM, the Activities Director (AD) stated R38's activities were mostly one-on-one. The AD stated R38 does not participate in group activities much because she doesn't seem interested. The AD stated R38 normally listens to music, visits with family, and has staff interaction once a day. The AD stated that his expectation of one-on-one activities would be an apron with tactile and sensation things on it, and I have one [an apron] in the dementia hall. The AD stated R38 is normally in her room and is only brought to the dining room right before lunch. The AD stated the activities assistants are the staff responsible for completing the one-on-one activities in R38's room and that it was his expectation these visits occurred twice a week. Upon conclusion of the interview, the AD stated, I guess we need to provide more one-on-one activities. Observation on 01/11/23 at 1:10 PM through 1:35 PM revealed R38 seated in her wheelchair in the dining room beside another resident. The two residents were not communicating. R38 had a sensory blanket on her lap that she was interested in briefly. There were no staff in the dining room at the time. Observation on 01/11/23 at 4:02 PM revealed R38 lying in bed in her room alone with the same sensory blanket on her lap. There was no radio or TV on in her room and the room was dark and quiet. Observation on 01/13/23 at 3:20 PM revealed R38 lying in bed in her room alone. There was no radio or TV on in her room. The sensory blanket was on the bedside table, but the table was out of R38's reach. Record review of R38's November 2022 Participation Record-Group, Individual, and Independent Engagement, provided by the AD on paper, revealed R38 participated in Current Events/News/Mail Independently 18 days that month. The document indicates R38 was Sleeping for that activity three times and Refused the activity eight times that month. The activity titled Exercise/Physical Activity/Walking indicated R38 was Actively Involved on 11/17/22. The activity titled Children/Intergenerational indicated R38 was marked as Minimal to No Response to Stimuli on 11/4/22. The activity titled Relaxing/Looking Out Window/Resting/Thinking indicated R38 participated Independently every day in November. The activity titled Socializing/Socials/Talking on Phone/Visits/Sending Cards indicated R38 had Limited Involvement 19 days, Minimal to No Response to Stimuli five days, Actively Involved one day, and One-to-One/Individual Visits and Response five days in November. No other activities were marked as being offered to R38 for November. Record review of R38's December 2022 Participation Record-Group, Individual, and Independent Engagement revealed R38 participated in Current Events/News/Mail with Minimal to No Response to Stimuli nine days, Independently eight days, Sleeping or Unavailable four days, and Refused three days. There were seven days in December blank under this title. The activity titled Socializing/Socials/Talking on Phone/Visits/Sending Cards indicated R38 had Limited Involvement 20 days, Minimal to No Response to Stimuli one day, and One-to-One/Individual Visits and Response three days in December. No other activities were marked as being offered to R38 for December.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40417 Based on interviews, record review, and review of the facility's policy, the facility failed to complete a change of condition assessment when the nursing staff had difficulty arousing with a sternal rub (A sternal rub is the application of painful stimulus with the knuckles of a closed fist to the center chest of a patient who is not alert and does not respond to verbal stimulit) through the night and into the next day for one resident (Resident (R) 75) out of a total sample of 28 residents. The facility's failed practice likely resulted in R75's death at the facility on [DATE]. Findings include: Review of facility-provided policy titled, Change of Condition, dated [DATE], revealed .A Center must immediately inform .the patient's physician a significant change in patient's physical mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications .to provide appropriate and timely information relevant to the patient's condition . Review of facility-provided policy titled, Assessment: Nursing, ,d+[DATE], revealed .The assessment process must include direct observation and communication with the patient, as well as communication with licensed and non-licensed direct care staff members on all shifts .To determine patient's condition and clinical needs . Conduct a change in condition assessment as needed using the eInteract Change in Condition Evaluation . Notify physician/advanced practice provider .of assessment results as indicated .Document physician . notification and response if indicated . Review of R75's undated ADMISSION RECORD, located in the Electronic Medical Record (EMR) revealed she was initially admitted to the facility on [DATE], readmitted on [DATE], and discharged (expired) on [DATE] with multiple diagnosis to include type 2 diabetes, acquired absence of left above knee, dementia, and delusional disorder (firmly held beliefs not based on reality). Review of R75's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], located in her EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) was not conducted and indicated R75 was severely cognitively impaired. Review of R75's Progress Note, under the Notes tab in the EMR revealed the following: [DATE] at 8:33 PM . Note: This writer [Licensed Practical Nurse 3] received report from the night nurse [LPN1], that this resident was heard moaning while asleep most of the time during the night. Sternum [sic] done by night nurse and resident was observed crying. This writer saw this resident between the hours of 0630 AM and 0700 AM. Resident was observed lying in bed in a supine position, had eyes closed and was heard making some moaning/snoring sound. Sternum rub was done and resident partially opened her eyes. Between the hours of about 0800 AM and 0815 AM . the CNA [Certified Nursing Assistant 4] called this writer to resident's room that this resident was non responsive. Resident was in a supine position. Sternum rub done and was nonresponsive. NO pulse felt. Body was warm to the touch. CPR (Cardiopulmonary Resuscitation) was started. 911 was called and came to assist. Resident was pronounced dead at 0853 AM. Resident's husband was notified and came to the facility with resident's two sons. Resident's body was picked up by [name of mortuary] at about 1314 (1:14) PM. Resident's husband and two sons picked up all resident's belongs . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 1:19 PM, LPN3 confirmed R75 was difficult to arouse (awaken) on [DATE]. LPN3 confirmed LPN1 reported to her R75 required a sternum rub to arouse. LPN3 confirmed she performed a sternum rub and R75 fluttered her eye lids. LPN3 confirmed when a resident was difficult to arouse that was something that should have been assessed further. LPN3 confirmed staff should assess everything from head to toe. LPN3 confirmed signs or symptoms for hypo (low blood sugar) or hyper glycemia (high blood sugar) could be difficult to arouse. LPN3 verified R75 had interventions on her care plan for medications that cause sedation. LPN3 confirmed R75 expired at the facility, over an hour later after LPN3 had applied a sternal rub and R75 fluttered her eye lids. During an interview on [DATE] at 4:55 PM, the Wound Care-Registered Nurse (WC) confirmed she would expect the nursing staff to assess R75 for her change of condition. WC confirmed difficult to arouse was considered a change in condition. RN confirmed R75 expired at the facility on [DATE]. During an interview on [DATE] at 6:38 PM, Registered Nurse (RN) 2 confirmed nurses were expected to assess residents with a change of condition. During an interview on [DATE] at 6:47 PM, the Unit Manager-Licensed Practical Nurse (UM) 1 confirmed she expected the facility staff to complete the steps on the change of condition assessment for a resident that was difficult to arouse and required a sternum rub to arouse. UM1 confirmed she expected her staff to follow through with change of condition assessment, including checking the blood sugar level, when R75 was initially found difficult to arouse by the night shift nurse (LPN1) and when the day shift nurse (LPN3) also had difficulty arousing R75. UM1 confirmed the facility failed to ensure R75 was provided quality of care. UM confirmed R75 expired on [DATE], hours after LPN1 and LPN3 had difficulty arousing her. During an interview [DATE] at 9:14 AM, the Medical Director confirmed her expectation for the facility's clinical staff was to assess R75 (upon the change of condition) on [DATE] not limited to but to include obtaining vital signs and checking her fingerstick blood sugar. The Medical Director stated R75's change of condition assessment was time sensitive, could be life threatening, required life sustaining treatment, and omittance could cause death. The Medical Director stated the facilities clinical staff had a history of not following policies and procedures. The Medical Director confirmed the facility's clinical staff not following policies and procedures was dangerous for residents. During an interview on [DATE] at 10:11 AM, the Medical Doctor (MD) confirmed he was a provider for residents at the facility including R75. MD confirmed he expected the facility staff to inform the medical provider of a resident's change in condition within 15 minutes of the change including (difficult to arouse and sternum rubs). MD confirmed provider notification was important for the facility to receive orders from the physician for diagnostic testing and treatment for the change in condition. During an interview on [DATE] at 08:47 PM LPN1 confirmed she provided care for R75 on the [DATE] night shift and reported to LPN3. LPN1 stated she did not check R75's blood sugar because it was not ordered by the physician. On [DATE] at 6:28 PM, the Administrator, the Clinical Lead Corporate, and Director of Nursing (DON) were notified of an Immediate Jeopardy (IJ) at F684-L: Quality of Care. The Immediate Jeopardy began on [DATE] when the nursing staff failed to complete an assessment for R75's change in condition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility provided an acceptable removal plan on [DATE] at 4:29 PM. The removal plan included Licensed nurses would complete assessments on current residents residing in the center to determine presence of a medical change in condition. Identified issues were reported to the physician. Identified changes in conditions that were not reported to MD (Medical Director) would be reported and medical orders would be followed, with monitoring. The Director of Nursing would educate current and auxiliary staff regarding the policy for resident change in condition. The survey team verified implementation of the Removal Plan and removed the IJ at F684 on [DATE] at 7:35 PM. The Administrator, the Clinical Lead Corporate, and DON were notified that the IJ was removed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46585 Based on interviews, record review, and policy review, the facility failed to provide a meal to cover the lunch hour dialysis treatment three days a week for one of one resident (Resident (R)86) reviewed for dialysis out of a total sample of 28 residents. This failure had the potential to create altered nutritional status and weight loss for R86. Findings include: Record review of the facility policy titled Dialysis: Hemodialysis (HD) Provided by a Certified Dialysis Facility, revised 06/01/21, under the Shared Communication Between the Center and the Certified Dialysis Facility section documented The communication process should include: Nutritional/Fluid management including documentation of weights, compliance with food/fluid restrictions, or the provision of meals before, during, and/or after HD, and monitoring intake and output measurements as ordered. Record review of R86's Admission Record, found in the Profile Tab in the Electronic Medical Record (EMR), revealed an admitted [DATE] with diagnoses including end stage renal disease, hemiplegia and hemiparesis (paralysis and weakness) following cerebral infarction (stroke), major depressive disorder, and vascular dementia. Record review of R86's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/11/22 documented R86 received dialysis treatments and required a therapeutic diet. Record review of the physician's Orders, located under the Orders tab in the EMR and dated 05/05/21, revealed that R86 was to receive a renal diet (low sodium, phosphorus and sodium) regular texture. There were no Physician's Orders for a meal to be provided to R86 to take with him on his dialysis days. Record review of R86's Care Plan, revised on 08/31/22 and located in the EMR Care Plan tab, documented [R86] is at moderate nutrition risk d/t [due to] higher protein needs . hemodialysis dependence. BMI [Body Mass Index] overweight. The Care Plan did not contain any documentation regarding meals for R86 on dialysis treatment days. During an interview on 01/09/23 at 12:48 PM, R86 stated he never received a sack lunch to take with him to dialysis. R86 stated sometimes when he gets back to the facility, his lunch tray is sitting on his bedside table. R86 stated most of the time there is no meal waiting, which he prefers, because he does not want to eat a meal that has been sitting there all day. R86 stated that he normally must skip lunch and wait for dinner on dialysis days. During an interview on 01/11/23 at 2:30 PM, the Dietary Manager (DM) stated that dialysis residents receive a sack lunch based on his/her dietary restrictions. The DM stated he was aware there was a dialysis resident currently at the facility, but we [kitchen staff] haven't made one [a sack lunch] in some time now. We haven't received any requests for one. The DM stated Certified Nursing Assistant (CNA), or the van driver usually make the requests if a sack lunch is needed. The DM stated he was unsure if a dialysis resident had to request a sack lunch to receive one. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/11/23 at 2:40 PM the Corporate District Dietary Manager (CDDM), revealed his expectation is to give a sack lunch to dialysis residents. The CDDM stated CNAs are expected to notify dietary staff of the resident's dialysis days and kitchen staff should prepare the sack lunch in advance. The CDDM stated the sack lunches require a physician's order, and once the dietary staff receive the order, a sack lunch is expected to be sent and should not require the resident to request it. The CDDM stated if a resident does not want the sack lunch, the kitchen can make them something when they get back. The CDDM stated it is not his expectation for meals to be left on the resident's table because it would need to be refrigerated. During an interview on 01/11/23 at 3:31 PM, the Corporate Lead Dietician (CLD) revealed his expectation was for a renal sack lunch to be prepared and sent with a dialysis resident. The CLD stated a resident does not require a physician's order for the sack lunches, and it should automatically be sent once their [the resident's] plan [Care Plan] has been established. During an interview on 01/12/23 at 8:42 AM, CNA3 revealed she had never seen R86 take a sack lunch with him to dialysis. CNA3 stated nursing staff sometimes leaves R86's lunch for him on his bedside table. She stated if R86 arrives back at the facility closer to dinner, staff just serve him dinner.

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F 0697 Level of Harm - Minimal harm or potential for 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** 40417 Based on interviews, record review, and review of facility policy, the facility failed to administer oxycodone as ordered by the physician and requested by the resident for one resident (Resident (R)236) of one resident reviewed for pain management in a total sample of 28 residents. This failure increased the potential for R236 to have unrelieved pain. Findings include: Record review of the facility provided policy for pain management revealed, .Staff will .implement strategies in accordance with professional standards of practice, the patient-centered plan of care, and the patient's choices related to pain management An individualized. interdisciplinary, person-centered care plan will be developed and included .pharmacological approaches .Using specific strategies for preventing or minimizing sources of pain or pain related symptoms . If a patient has a change in pain status, complete an e-Interact Change in Condition assessment and Pain Evaluation . Record review of R236's undated ADMISSION RECORD, located in the Electronic Medical Record (EMR) revealed he was admitted to the facility on [DATE] with multiple diagnosis to include abscess of the lung with pneumonia. Record review of R236's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/02/23, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) with a score of 15 out of 15 indicating R236 was cognitively intact. Record review of R236's Physician's Orders, under the Orders tab located in the EMR, revealed . oxyCODONE-Acetaminophen Oral Tablet (Oxycodone w/Acetaminophen) 10-325 MG (Milligram) Give 1 tablet by mouth every 6 hours as needed for PAIN -Start Date-12/26/2022 1830 (6:30 pm) -D/C Date-01/03/2023 1151(11:51 am) - . Oxycodone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. Oxycodone is also available in combination with acetaminophen (Percocet). Record review of R236's comprehensive Care Plan, under Care Plan tab located in the EMR, revealed there was no focus area or interventions for pain management. Record Review of R236's Notes, under the Notes tab located in the EMR revealed . 01/01/23 .Resident complained of left supraclavicular [above the collar bone] pain 6/10 (scale with 10 being the highest pain) to med tech [medication technician] . Record review of R236's Medication Administration Record (MAR), dated 12/2022 and 01/2023 under Orders tab in the EMR, revealed the following: .oxyCODONE-Acetaminophen Oral Tablet 10-325 MG (Oxycodone w/Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for PAIN -Start Date-12/26/2022 .-D/C Date-01/03/2023 . without staff initials for 12/26/23-01/03/23, indicating the medication was not administered by the facility staff. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MARs, dated 12/2022 and 01/2023 and located in the Orders tab in the EMR, revealed the order for Acetaminophen (Tylenol) 325 mg give two tablets by mouth every six hours as needed for pain with a start date of 12/26/22. Further review of these MARs revealed staff initialed that the Tylenol was administered on 12/26/22, 12/29/22, 12/30/22, and 01/01/23 and was documented as effective. Review of the MAR, dated 01/2023, revealed the order was changed to Acetaminophen 325 mg three times a day for back pain with a start date of 01/10/23. Staff initialed that this order was administered on 01/03/23 at 8:00 PM and then from 01/04/23 through 01/09/23 three times a day. During an interview on 01/10/23 at 11:14 AM, R236 stated he was not provided with his pain medication oxycodone because the facility did not have it in stock since his admission (12/26/22) to the facility. R236 stated he requested it three times after his admission to the facility and instead the facility staff gave him Tylenol. R236 stated the staff informed him his narcotic oxycodone was not delivered to the facility by the pharmacy. R236 stated he waited for weeks for the medication to be delivered to the facility. R236 stated his narcotic pain medication was delivered to the facility about two days ago (01/08/23) and was the first time the facility administered a dose to him since his admission. During an interview on 01/13/23 at 10:36 AM, Licensed Practical Nurse (LPN) 4 confirmed R236 requested oxycodone for pain and the facility did not provide it to him. LPN confirmed R236 had an order for oxycodone pain medication. During an interview on 01/13/23 at 8:31 PM, LPN1 confirmed R 236 complained of pain on a Sunday 01/01/23 but was not administered his oxycodone pain medication. LPN1 confirmed a Certified Medical Technician administered Tylenol for R236's pain. During an interview on 01/13/23 at 6:29 PM, Clinical Lead Corporate (CLC)1 confirmed R236 was admitted to the facility with an order of Percocet (the generic name for Percocet is oxycodone acetaminophen). CLC1 confirmed the facility did not administer R236 oxycodone from 12/26/22 to 01/05/23. CLC1 confirmed R236 was administered Tylenol for pain. CLC1 stated she was unsure why R236 was not administered his narcotic pain medication, oxycodone. During an interview on 01/13/23 at 7:15 PM CLC1 confirmed her expectation for the facility's clinical staff was to administer R236's narcotic pain medication. CLC1 confirmed if R236's oxycodone was not in his medication supply, she expected the facility staff to remove his oxycodone medication dose from the Omnicell [Omnicell's automated medication dispensing system and supply automation products provide a comprehensive, end-to-end solution for managing the supply chain]. CLC1 confirmed there was no documentation in R236's EMR by facility staff indicating why his requested dose of pain medication oxycodone was not administered to him.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40417 Based on interviews, observations, and review of records, the facility failed to ensure the staff were competent with skills and knowledge to provide care for one of one resident (Resident (R) 236) reviewed for care of a chest tube out of a total sample of 28 residents. The facility's deficient practice likely resulted in the chest tube being blocked and unable to be removed. Findings include: During an interview 01/12/23 at 5:22 PM, Clinical Lead Corporate (CLC)1 confirmed the facility did not have a staff competency policy. Record review of facility-provided binder titled In-Service 2022 for 01/2022 through 12/2022 revealed no in-service or competency training for the facility staff for chest tubes. Record review of R236's undated ADMISSION RECORD, located in the Electronic Medical Record (EMR), revealed he was admitted to the facility on [DATE] with multiple diagnosis to include abscess of the lung with pneumonia. Record review of R236's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/02/23, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) with a score of 15 out of 15 indicating R236 was cognitively intact and had diagnosis pneumonia with a surgical wound. Record review of R236's HOSPITALIST PROGRESS NOTE, dated 12/17/22 under the Documents tab located in the EMR revealed .Pulmonary .right chest wall drainage catheter [chest drains, also referred to as chest tubes], . Record review of R236's comprehensive Care Plan, under Care Plan tab located in the EMR, revealed no focus, goal, or interventions for assessment of chest tube complications including tension pneumothorax, trauma to intrathoracic structures, intra-abdominal structures and intercostal muscles, re-expansion pulmonary edema, hemorrhage (bleeding from blood vessel) incorrect tube position, blocked tube, pleural drain dislodgement, or subcutaneous emphysema (air get into tissue under the skin) or management to include securing the tubing to avoid pulling chest tube out and positioning the drainage collection bag. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 01/10/23 at 10:58 AM, R236 had an un-dated clean, dry, and intact dressing to his right upper back with his chest tube leading to his drainage collection bag with reddish/yellow liquid. R236 stated his dressing on his chest tube insertion site was applied on 01/09/23 during his doctor's appointment. R236 stated from the date of his admission to the facility on [DATE] until 01/08/23 the facility did not provide him with care for his chest tube including changing his chest tube insertion site dressing, emptying his chest tube drainage collection bag, or flushing his chest tube. R236 stated he requested the facility staff change the dressing around his chest tube insertion site multiple times because he had drainage oozing out around his insertion site and it leaked all over his shirt and his bed sheet. R236 stated he continued to report to the staff there was drainage all over his bed and his shirt, but the staff ignored his request. R236 stated his shirt looked like he had been in a paint ball fight [from the drainage]. R236 stated the drainage from his insertion site ran down his back. R236 stated Licensed Practical Nurse (LPN) 4 changed his chest tube insertion site dressing on 01/08/23 for the first time since his admission (12/26/22). R236 stated he had a follow up appointment on Monday (01/09/23) to have his chest tube removed but the doctor was unable to remove it. R236 stated he was informed, by the doctor, the end of his chest tube was stopped up because the facility had not provided care for it. R236 stated the facility staff should have changed his chest tube insertion site dressing, emptied his drain, and flushed his tubing daily but had not. R236 stated he was unable to empty his own drainage because he was not educated on how to empty his chest tube collection drainage bag. Record review of R 236's Physician's Orders, under Orders tab located in the EMR, revealed, . Change dressing to upper back w (with)/sterile drain sponge QD (one time a day) -Start Date-01/05/2023 [11 days after admission to the facility] 1000 (10:00 am) -D/C (Discharge) Date-01/10/2023 1435 (2:35 pm) and .FLUSH IR DRAIN TO UPPER RIGHT BACK WITH 5CC NS QD in the evening for IR DRAIN PATENCY -Start Date- 01/09/2023 [15 days after admission to the facility] 2000 (8:00 pm) -D/C Date- 01/10/2023 1435 (2:35 pm) . Further review of the physician's orders revealed no orders for assessment for complications of chest tube or emptying chest tube drainage bag. During an interview on 01/11/23 at 5:54 PM, Certified Nursing Assistant (CNA)3 confirmed the facility did not provide her with training or ensure she was competent with the knowledge and skills to provide care for residents with chest tubes. During an interview on 01/11/23 at 6:12 PM Registered Nurse (RN)2 confirmed the facility did not provide him with training or ensure he was competent with knowledge and skills to provide care for residents with chest tubes. During an interview on 01/11/23 at 7:22 PM, Unit Manager- Licensed Practical Nurse (UM) 1 confirmed the facility did not provide her with training or ensure she was competent with the knowledge and skills to provide care for residents with chest tubes. UM1 confirmed the facility should provide all clinical staff education for care of residents with chest tubes. (continued on next page)

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	01/13/2023

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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/23 at 10:17 AM, LPN4 confirmed the facility did not provide her with training or ensure she was competent with the knowledge and skills to provide care for residents with chest tubes. LPN4 confirmed the facility should ensure the staff were competent and trained to provide chest tube care for residents. LPN 4 verified R236 did not have a physician order for care of his CT (chest tube). LPN stated R 236's dressing was saturated on Sunday 01/08/23. LPN4 stated R236 complained the drainage had run down his back. LPN4 stated she removed his saturated dressing and re-dressed the insertion site. LPN4 stated she was concerned about his CT falling out because his suture appeared broken and not secured. LPN4 stated he refused to be sent out saying he had a doctor's appointment the following day. LPN4 stated she redressed the site and taped the tubing to secure it. LPN4 stated R236 physician's office called the next day and stated the tube was blocked because the facility had failed to flush the drain. LPN4 stated the facility had no order to empty R236's drain, to flush it, and no physician's order to change his dressing around his insertion site until 01/05/23. LPN4 confirmed the facility staff had not been trained to flush R236's CT tube. LPN4 confirmed CT complications could be life threatening. LPN stated if R236's CT fell out she would send him out via 911 because she had not received training regarding chest tubes. During an interview on 01/13/23 at 11:59 AM Staff Educator-Registered Nurse (SE) confirmed the facility did not provide her with training or ensure she was competent with the knowledge and skills to provide care for residents with chest tubes. SE confirmed chest tube complications could be life threatening. During an interview on 01/13/23 at 7:50 PM, CLC 1 confirmed the facility did not have clinical capabilities to provide care for residents with chest tubes.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40417 Based on record review and interviews, the facility failed to administer antibiotic medication as ordered for to two of two residents (Resident (R) 234 and R230) reviewed for antibiotic use in a total sample of 28 residents. This failure could likely increase the risk of ineffective treatment for infection resulting in worsening infection. Findings include: 1. Record review of R234's undated ADMISSION RECORD, located on her Electronic Medical Record (EMR) revealed she was admitted to the facility on [DATE] with multiple diagnosis to include bacterial meningitis (Meningitis is an infection of the membranes (meninges) that protect the spinal cord and brain) and osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the lumbar (lower back) spine. Record review of R234's comprehensive Care Plan, under the Care Plan tab in the EMR, revealed .has actual colonization/ infection with MSSA [Methicillin sensitive Staphylococcus aureus-bacteria] and is at risk for sepsis [injury to tissues and organs as a response to infection] R/T [related to] recent episode of septic shock [low blood pressure from sepsis]. Date Initiated: 01/10/2023 . Administer antibiotics per order. Date Initiated: 01/10/2023 . Record review of R234's Physician's Orders, under the Orders tab located in the EMR, revealed .Nafcillin Sodium Intravenous Solution Reconstituted (Nafcillin Sodium) [antibiotic] Use 12 gram intravenously in the morning for Infuse 12 gms over 24 hours continuous infusion -Start Date- 01/10/2023 . Record review of R234's Medication Administration Record (MAR), dated 01/2023 and under the Orders tab in the EMR, revealed, .Nafcillin Sodium Intravenous Solution Reconstituted (Nafcillin Sodium) Use 12 gram intravenously in the morning for Infuse 12 gms [grams] over 24 hours continuous infusion -Start Date- 01/10/2023 . NN (NN=No /See Nurse Notes) with staff initials entered on 01/12/23 at 8:00 AM, indicating the medication was not administered. Record review of R234's Progress Notes, under the Notes tab located in the EMR, revealed .01/12/23 at 8:00 PM .Nafcillin Sodium Intravenous Solution Reconstituted Use 12 gram intravenously in the morning for Infuse 12 gms over 24 hours continuous infusion Pending medication delivery; Patient made aware; NP (Nurse Practioner) made aware; medication to be started when it arrives from pharmacy; Pharmacy states medication to be delivered on pharmacy run . by Unit Manager (UM)1. During an interview on 01/13/23 at 6:29 PM with two of the facility's Clinical Leads Corporate, (CLC)1 and CLC2, CLC1 confirmed she expected the clinical staff to administer the medications as ordered. CLC2 confirmed R234 was not provided her dose of antibiotic on 01/12/23 by the facility, and she was unsure why. CLC2 confirmed R234 had a nurses note verifying R234's antibiotic was continuous infusion. During an interview on 01/13/23 at 6:48 PM, UM1 confirmed R234 had a physician's order for antibiotic administration by continuous infusion. UM1 confirmed the facility did not administer R234's antibiotic dose on 01/12/23. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of R230's undated ADMISSION RECORD, located in the EMR, revealed he was admitted to the facility on [DATE] with multiple diagnosis to include Parkinson's disease and metabolic encephalopathy (neurological disorders caused by systemic illness). Record review of R230's comprehensive Care Plan, under the Care Plan tab in the EMR, revealed .has an actual infection and is at risk for sepsis R/T recent hospitalization for sepsis Date Initiated: 01/06/2023 . Administer IV abt [antibiotic] as ordered Date Initiated: 01/06/2023 . Record review of R230's Physician's Orders, under Orders tab located in the EMR revealed the following: a.Sodium Chloride Solution [saline] 0.9 % Use 10 ml intravenously (injected in the vein) .1/7/2023 . b.cefTRIAXone Sodium [antibiotic] Intravenous Solution Use 2 gram (GM) intravenously .1/5/2023 . c.Vancomycin HCl [antibiotic] Intravenous Solution 1000MG (miligram) /10ML (Vancomycin HCl) Use 1000 mg intravenous . 1/5/2023 . d.Ampicillin Sodium [antibiotic] Intravenous Solution Reconstituted 2 GM (Ampicillin Sodium) Use 2 gram intravenously .1/5/2023 . Record review of R230's MAR, dated 01/2023 under the Orders tab located in the EMR, revealed the following: a.Ampicillin Sodium Intravenous Solution Reconstituted 2 GM (Ampicillin Sodium) Use 2 gram intravenously every 4 hours for Leukocytosis [increased white blood cell count indicating infection] for 33 Administrations -Start Date- 01/05/2023 with NN (NN=No / See Nurse Notes) entered for 01/05/22 at 11:00 PM, 01/06/22 at 7AM, 11 AM, 3 PM and 7 PM and HD (HD=Hold/See Nurse Notes) for 3 AM indicating not administered. b.cefTRIAXone Sodium Intravenous Solution Reconstituted 2 GM (Ceftriaxone Sodium) Use 2 gram intravenously every 12 hours for Leukocytosis for 11 Administrations -Start Date- 01/05/2023 2200 (10:00 pm) . 01/05/22 at 10:00 PM and 01/06/22 at 10:00 AM revealed NN entered indicating the medication was not administered. c.Vancomycin HCl Intravenous Solution 1000 MG/10ML (Vancomycin HCl) Use 1000 mg intravenously every 24 hours for Leukocytosis for 5 Administrations -Start Date- 01/05/2023 1800 (6:00 pm) with NN entered for 01/05/23 and 01/06/23 indicating the medication was not administered. Record review of R230's Progress Notes, under the Notes tab located in the EMR, revealed no note on 01/05/23 or 01/06/23 explaining why the Ampicillin Sodium Intravenous, Ceftriaxone Sodium Intravenous Solution, and Vancomycin HCl Intravenous Solution medications were not administered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/11/23 at 7:22 PM, UM1 verified the facility did not provide R230 his IV antibiotic medications for 01/05/22 and 01/06/22. UM1 confirmed the nursing staff did not include a note indicating they informed the resident's physician or the facility management that the medication was not available. UM1 confirmed her expectation for the nursing staff was to inform facility management and the physician that a resident's medication was not available and missed administration. During an interview on 01/13/23 at 10:28 AM, Licensed Practical Nurse (LPN)4 verified the missed doses of antibiotics on 01/05/23 and 01/06/23 documented on R230's MAR. LPN4 stated there was no reason R230 antibiotics should not have been at the facility. LPN4 stated it was super important that R230 received all his doses of antibiotics because he was septic at the hospital. LPN4 confirmed sepsis could be life threatening. LPN4 stated the pharmacy delivers the medication on time, but the problem was the nursing staff at night were not requesting the medication from the pharmacy. During an interview on 01/13/23 at 6:30 PM, CLC1 confirmed the facility did not administer R230's doses of antibiotics on 01/05/23 and 01/06/23.