

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Skyline Heights Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1807 24th St W Billings, MT 59102	
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to prevent, identify, assess, measure, document, and implement necessary interventions for the prevention of avoidable pressure ulcers that developed shortly after a resident's admission, for 1 (#1) of 18 sampled residents. The resident had one Stage III on his heel and one Stage III on the gluteal area, which were both avoidable. The deficient practice placed the resident at risk of having a deterioration of the pressure ulcer. Findings include: Review of resident #1's medical record showed she was admitted on [DATE], with a diagnosis of diabetes, heart disease, hypothyroidism, and kidney disease (not all inclusive). Review of resident #1's EHR showed the following related to pressure ulcers/care: - The facility nursing progress notes dated 5/4/26 at 3:38 p.m. showed resident #1 was admitted to the facility following surgical repair of a fractured hip. - On the admission skin assessment, dated 5/4/26, resident #1 had multiple bruised areas (front of her right shoulder, right front axilla, right breast, right temporal area, abdomen, right outer forearm, right dorsum of her right hand, left outer forearm, left antecubital space, right antecubital space, left dorsum of left hand), one surgical wound (right trochanter). The assessment showed resident #1 had no pressure ulcers present upon admission. Review of resident #1's baseline care plan dated 5/5/26 showed the resident was at risk for skin impairment related to a diagnosis of Diabetes. The goal for resident #1's skin was to be free of redness, blisters, and discoloration through the next review date. The care plan centered around resident #1's legs and feet, but not other areas of the body at risk, and included the following interventions:-Ensure blankets are not tight against toes.-Moisturizing lotion to bilateral lower extremities to include the feet.-Notify Provider as needed.-Offer off-loading of heels when in bed.-Proper fitting shoes.-Routine nail care.-Routine Weekly Skin assessments. Review of resident #1's admission Minimum Data Set assessment, with an assessment reference date of 5/10/26, showed resident #1 was not at risk of developing pressure ulcers/injuries. The assessment showed resident #1 did not have any pressure ulcers upon admission. Review of facility nursing progress note dated 5/11/26 at 10:20 p.m. showed, Patient was seen by wound care nurse related to buttock. The documentation did not describe the identified skin problem on the resident's buttocks. Resident #1's nursing note did not identify or reflect information on the stage (severity determination) or the measurements of the resident's skin concern area. Review of the wound nurse's progress note written on 5/12/26 at 1:01 a.m. showed the facility wound nurse documented there was a situation/concern for resident #1's right and left gluteal fold, and the skin region needed further assessment. The wound nurse's progress note requested wound care recommendations for the resident's gluteal region, but the gluteal region concerns for #1 were not described in the note. Review of progress notes dated 5/12/26 at 6:53 p.m. showed, Skin Issue: #10: Skin issue has not been evaluated. Location: Left heel. Laterality/Orientation: Left. Issue type: Pressure ulcer/injury. Wound was present on admission. The note did not show if the wound was (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 0686 Level of Harm - Actual harm Residents Affected - Few	avoidable or unavoidable. The pressure ulcer was not evaluated for stage or size. This note contradicts the admission note written on 5/4/26, which showed resident #1 had no pressure ulcers on admission, and it was documented eight days after the resident's admission, and it was the first documentation of the left heel pressure ulcer. The documentation did not show the stage, size, or description of the heel wound. Review of the resident #1's physician assistant's provider notes, dated 5/18/26, showed the concern for resident #1 was a urinary tract infection and low blood glucose readings. The note did not show the nurses made the provider aware of resident #1's heel pressure ulcer. Resident #1's heel pressure ulcer was not noted in the physician assistant's provider notes. A review of the dietitian's assessment, dated 5/18/26, showed the resident was started on Boost, a nutritional supplement. Review of resident #1's May 2026 treatment records showed a physician's order dated 5/19/26 directing staff to monitor the Stage III pressure injury to the resident's left heel and monitor for signs and symptoms of infection or deterioration and document the findings. The staff was to notify the provider if complications were noted. If the wound was covered by a dressing, and the dressing was not ordered to be changed at that time, the nurses were to note the condition of the dressing and any global indicators of infection every shift. There was no treatment ordered for the pressure ulcer for resident #1's left heel. The physician ordered diabetic skin care to resident #1's lower extremities. Review of resident #1's physician order on the treatment records included: moisturizing lotions, off-loading heels, soft boots, an air mattress, routine nail care, proper fitting shoes, and ensure blankets are not tucked in too tight. The staff was directed to choose which intervention was implemented and document when it was used. Review of resident #1's nurse progress notes dated 5/21/26 at 3:15 a.m. showed only three skin issues, which included a surgical wound on the right front trochanter, bruising on the right front axilla, and the abdomen. The resident's heel Stage III pressure ulcer and the sacrococcygeal (gluteal fold) pressure ulcer had not been documented as resolved; however, they were not documented as ongoing wounds. Review of resident #1's nurse's notes dated 6/14/26 at 5:17 a.m. showed resident #1 had a skin issue described as, Skin issue has not been evaluated. Location: Left Gluteus. Additional location information: dry, dark brown, peri wound was hyperpigmented, Issue type: Other skin issue. Other skin issue description left upper gluteus Wound acquired in-house. Undermining: No. Tunneling: No. [sic] The progress note did not show what type of wound was acquired on resident #1's gluteus, if the wound was avoidable, and there were no notes for the measurements or severity determination of the wound. The right side of the resident's gluteus was not documented on. Review of resident #1's June 2026 medication and treatment record showed the left gluteal region wound and peri wound (area around the gluteal region) was to be cleansed with wound cleaner; Skin prep was then to be applied to the peri wound. Then an island dressing/Opti foam was to be applied to the affected area every shift. It was noted resident #1 was to be followed by a [Name] wound care team two times a day for wound care. There were no physician orders for treatment of resident #1's gluteal region on the June treatment record. It was unclear if the wound was on the left side or right side, or if it had grown into one wound on the gluteus. Review of Resident #1's nursing note, dated 6/14/26, completed by the wound nurse, reflected the physician assistant was contacted by phone, and it was reported resident #1 had a Stage III pressure sore on gluteal region. The left/right side was not mentioned, and the Staging of the wound was identified by the nurse. Review of resident #1's physician assistant's notes, for a telephone encounter, dated 6/14/26, showed an Unstageable wound to the left gluteus. Although the nurse who contacted the physician assistant on 6/14/26 reported a Stage III wound, the provider noted it was Unstageable but did not visualize the wound personally at that time. There were no measurements of the wound. There was documentation to show there was some erythema and (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	responsible for updating the care plans Monday through Friday with changes in the resident's condition. Review of resident #1's current care plan effective through the date of her hospitalization on 6/30/26, showed the facility failed to update the care plan to include the pressure ulcer to resident #1's sacrococcygeal (gluteal) area, which started on 5/21/26, and the Stage III pressure ulcer on her left heel which was present on 5/12/26. The care plan was unchanged from the baseline admission care plan. On 7/14/26 at 4:05 p.m., the surveyor requested all the weekly skin and wound assessments for resident #1. The request was to include the wound description, stages, and measurements for resident #1's pressure ulcers on her left heel and her gluteal area. By the end of the survey on 7/17/26, no documentation was received for the left heel pressure wound. Two sets of wound measurements for the sacrococcygeal wound were received. The wound measurements were taken at a physician's appointment on 6/23/26 and 6/30/26. A review of the facility's Policy and Procedure titled Wound Treatment Management, which was undated, showed: 1. Wound treatments will be provided in accordance with the physician's orders, including the cleansing method, type of dressing and frequency of dressings. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. Based on the policy, the review of resident #1's medical record reflected the policy was not followed, as resident #1's Stage III pressure ulcer did not have treatment orders, and the wound had been present for two months. There were no progress notes showing the nurses requested treatment for the wound. A review of the facility's Policy and Procedure titled Pressure Injury Prevention and Management, undated, and not followed by licensed staff per record reviews, showed: 2. The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of interventions; and modifying the interventions as appropriate. Review of resident #1's medical record and the Recertification survey plan of correction dated 4/3/26 showed the facility failed to carry out or sustain corrections identified in the plan of correction. Facility staff did not identify the wounds and immediately implement measures to prevent a deterioration of a skin concern or wound. Wound documentation was either not done or inconsistent for the wound location, description and details, size, and severity. Staff did not follow the facility policies and procedures, and/or ensure the resident attended all wound care appointments, which further contributed to the overall failure. The resident's care plan was not inclusive of necessary interventions to prevent the development and/or care of pressure ulcers on the resident's heel and/or gluteal area. deterioration of the wound(s).		