STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325064	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skies Healthcare & Rehabilitation Center	9150 McMahon Boulevard NW Albuquerque, NM 87114

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 52443 Based on record review and interview, the facility failed to promote resident choices for 1 (R #9) of 1 (R #9) resident reviewed for choices when staff failed to offer R #9 showers per her preference. This deficient practice is likely to result in the residents' personal choices not being honored. The findings are: A. Record review of the facility's bath and shower schedule revealed R #9 was scheduled to bathe or shower on Tuesday, Thursday and Saturdays. B. Record review of R #9's care plan dated 03/16/25 revealed the following: -Focus: R #9 requires assistance for ADL (Activities of Daily Living) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion and tilting. C. On 04/15/25 at 8:55 am during an interview with R #9, she stated that she cannot shower as often as she would like due to the shortage of Certified Nursing Assistants (CNAs). R #9 stated she would like to shower every day, but she is told by nursing staff that she cannot shower because there are not enough staff available to take her. R #9 stated she feels anger, sadness, dread, and if I don't control my emotions I'd be depressed, when she cannot receive a shower everyday as she would like. D. On 04/15/25 at 11:17 am during an interview with CNA #7, she stated, residents can't be there (shower) alone in case they fall. Short staffing leads to delays in showers. E. On 04/15/25 at 3:19 pm during an interview with Unit Manager (UM) #1, he confirmed residents are allowed to shower more than the scheduled three times per week. UM #1 stated the residents aren't allowed to shower alone due to safety concerns. UM #1 confirmed short staffing affects showers. F. On 04/16/25 at 12:50 pm during an interview with Director of Nursing (DON), he confirmed showers depend on staffing because they're not allowed to be in the shower by themselves due to safety concerns. DON stated they are short staffed, and it does affect the shower schedule. DON confirmed extra showers are not allowed when they are short staffed.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52443 Based on record review, observation and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance for baths and showers by the facility staff for 2 (R #'s 5, and 6) of 2 (R #'s 5, and 6) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: R #5: A. Record review of R #5's face sheet revealed R #5 was admitted to the facility on [DATE]. B. Record review of R #5's care plan 02/11/25 revealed R #5 is at risk for decreased ability to perform ADLs related to: Limited mobility, history of multiple fractures including hip fracture, chronic obstructive pulmonary disease, pain and obesity. C. Record review of the facility's bath and shower schedule revealed R #5 was scheduled to bathe or shower on Tuesday, Thursday, and Saturdays. D. Record review of R #5's documentation survey report (Activities of Daily Living - ADL tracking form), dated 03/31/25 through 03/31/25, revealed staff offered and gave R #5 six baths or showers out of thirteen opportunities. E. Record review of R #5's shower sheets, dated 03/1/25 through 03/31/25, revealed staff offered and gave R #5 six baths or showers out of thirteen opportunities F. Record review of R #5's documentation survey report (Activities of Daily Living - ADL tracking form), dated 04/01/25 through 04/15/25, revealed staff offered and gave R #5 three baths or showers out of seven opportunities. G. Record review of R #5's shower sheets, dated 04/01/25 through 04/14/25, revealed staff offered and gave R #5 three baths or showers out of seven opportunities. H. On 04/14/25 at 11:13 am during interview, R #5 stated she went seven days without a shower or bath two weeks ago (3/26/25 through 3/31/25) R #5 stated she gets so embarrassed without a bath and she doesn't even want people standing around her. I. On 04/14/25 at 4:04 pm during an interview with Certified Nursing Assistant (CNA) #4, she stated the facility being short staffed definitely affects the shower schedule. CNA #4 stated it's tough keeping up with showers and residents who are bedbound miss their baths more. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. On 04/15/25 at 10:30 am during an interview with CNA #4, she stated, I' ve done one shower today, eight residents are scheduled for showers. CNA #4 stated I don't believe, I will get to all of them today. CNA #4 stated because we're short staffed all the time, residents aren't getting showered as often as they should. K. On 04/15/25 at 10:48 am during an interview with CNA #6, she stated she is not able to get resident showers completed and her other duties as assigned. CNA #6 further stated the missed shower issues come from the facility being understaffed. L. On 04/15/25 at 11:17 am during an interview with CNA #7, she stated she was hired as a designated shower aid, but was moved to other CNA duties due to the staff shortage. CNA #7 stated how am I supposed to get eight showers done in a day? CNA #7 stated a full assist shower can take up to 1 hour and 30 minutes. M. On 04/15/25 at 2:37 pm during an interview, Registered Nurse (RN) #1 stated sometimes we don't have staffing and sometimes people call off. We try to get the showers done, there are some showers done at night. RN #1 stated, Yes, resident showers do get missed. N. On 04/15/25 at 3:19 pm during an interview, the Unit Manager (UM) #1 stated no, there is absolutely no reason a resident should go seven days without a shower. O. On 04/16/25 at 12:50 pm during an interview, the Director of Nursing (DON) stated yes, it is accurate that we are short on staff, and it is affecting the shower schedule. DON stated they have several positions open at this time. R #6: P. Record review of R #6's face sheet revealed R #6 was admitted to the facility on [DATE] Q. Record review of R #6 care plan dated 01/14/25 revealed, R #6 is at risk for decreased ability to perform ADLs related to: dementia (memory loss), schizophrenia (mental disorder), Chronic Obstructive Pulmonary Disease (progressive lung disease that makes it difficult to breath). R #6 is at risk for infections due to a behavior of frequent inappropriate touching of genitalia. Staff is to assist with hand hygiene. R. Record review of the facility's bath and shower schedule revealed R #6 was scheduled to bathe or shower on Tuesday, Thursday, and Saturdays. S. Record review of R #6's documentation survey report dated 01/01/25 through 02/28/25, revealed staff offered and gave R #6 seven baths or showers out of twenty-five opportunities. T. Record review of R #6's shower sheets, dated 01/01/25 through 02/28/25, revealed staff offered and gave R #6 two baths or showers out of twenty-five opportunities U. Record review of R #6's documentation survey report, dated 03/01/25 through 03/31/25, revealed staff offered and gave R #6 seven baths or showers out of thirteen opportunities. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Record review of R #6 documentation survey report, dated 04/05/25 through 04/12/25 revealed staff did not offer or give R #6 a bath or shower. Zero out of four opportunities. W. Record review of R #6's shower sheets, dated 04/05/25 through 04/12/25, revealed staff did not offered R #6 zero baths or showers out of four opportunities. X. On 04/14/25 at 12:44 pm during an observation of R #6, she was in the hall, in a wheelchair. R #6 looked disheveled and unkept with pants and brief around knees scratching her groin area. CNA #1 came by ten minutes into the observation and helped to get R #6 dressed and covered up. Y. On 04/15/25 at 8:50 am during an observation of R #6 and interview, she was in a wheelchair after a shower and she was smiling and happy, with her clothes on properly. R #6 stated that she received a shower that morning and she always feels better after a shower.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review, observations, and interviews, the facility failed to ensure the PEG (Percutaneous (through the skin) Endoscopic (a medical procedure that uses a scope to look into the digestive system) Gastrostomy (a surgical procedure that creates an opening through the abdominal wall) tube (a device utilized to provide liquid nutrition and medications, via a tube into the stomach or intestine) for 1 (R #1) of 1 (R #1) resident, was managed according to current acceptable standards of practice to ensure safety of the resident. This deficient practice could cause significant health problems such as infection or displacement of the tube The findings are: A. Record review of R #1's face sheet dated 04/18/25 revealed she was admitted to the facility on [DATE] with the following diagnoses: -Cerebral (brain) Infarction (damage of tissue due to blood loss) (stroke). -Gastrostomy (surgical opening through the abdominal wall and into the stomach). B. Record review of R #1's provider orders dated 04/14/25 revealed the following: -02/11/25 an order to provide a dysphagia (difficulty swallowing) advanced texture diet (a nearly regular diet that avoids hard, sticky or crunchy foods) standard thin liquids. -09/09/24 Enteral (within the intestine) Feed Order every 4 hours 300 ml (milliliter) free water flushes. No other current provider order was found regarding PEG tube care, PEG tube feed, PEG tube medication administration. C. Record review of R #1's Point of Care (POC) Tasks (a review of those activities of daily living (ADL's)) dated April 2025 revealed that R #1 was offered and accepted drinks and snacks on a daily basis and that she consumed 75% or more of each of her meals. D. On 04/14/25 at 10:30 am during observation of R #1 and interview, R #1 was in her room, in her bed. She was alert, responsive and interactive. She provided information about her past health care and her current concerns. R #1 stated she had a PEG tube and that was placed while she was in the hospital and before she was admitted to the facility on [DATE]. She stated that the PEG tube was used to provide nutrition and medications until about January 2025. She stated that she was then placed on a diet and provided daily meals which she consumed. She stated the PEG tube was not used by staff to provide nutrition. R #1 stated she had asked about the tube and was told by nursing staff that the tube was probably going to be removed some time soon. She could not recall the staff nurse who told her this. R #1 stated the staff still cleaned the PEG tube site and still flushed water into the PEG tube site but she had not received any nourishment through the tube since January 2025. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 04/15/25 at 9:25 am during interview with Nurse Practitioner (NP) #1 she stated she was aware of R #1's condition and medical history. She stated R #1 was admitted due to a stroke and she was unable to swallow. NP #1 stated that R #1 had a PEG tube placed while in the hospital and she was admitted to the facility with the PEG tube. She stated for some time following admission until January 2025, R #1 was provided nutrition through the PEG tube. NP #1 stated that the PEG tube was not being used at this time and was only being maintained. She stated that she would normally have reviewed her current status and considered her for removal of the PEG tube but she had simply forgotten about R #1 having a PEG tube. NP #1 stated that it is best that PEG tubes be considered for removal when they are no longer needed and not being used. She stated that R #1 had not used her PEG tube for nutritional needs for several months. NP #1 stated there are risks for a PEG tube including infection. F. On 04/16/25 at 12:54 pm during interview with Director of Nursing (DON), he stated that he felt R #1 was still at risk of having another significant stroke and that as a precaution the PEG tube was being left in place.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview, the facility failed to ensure residents had a written, signed, and dated progress note from their physician after each visit for 1 (R # 2) of 1 (R # 2) resident reviewed for current physician progress notes and documentation. This deficient practice is likely to result in resident's records being incomplete and resident care not being documented and reviewed. The findings are: A. Record review of R #2's face sheet dated 04/16/25 revealed that she was admitted to the facility on [DATE] with the following diagnoses: -Delusional (thoughts that are not real) Disorders -Major Depressive (a feeling of sadness) Disorder -Dementia (a chronic, progressive disorder that reduces memory and recall) The face sheet further revealed that her care provider (PCP) was not a physician that was associated with the facility, but had admitting privileges to the facility. The PCP was associated with a local clinic (LC) within the community. B. Record review of R #2's Electronic Medical Record (EMR) including all daily care notes, all miscellaneous documents and all provider notes revealed the record did not contain any physician notes of any visits. C. Record review on 04/17/25 the facility provided a copy of a provider note dated 01/09/25. No other notes were provided. D. On 04/16/25 during interview with Director of Nursing (DON) he confirmed that there were not provider notes that had been submitted by the PCP in R #2's medical record. He stated the assigned PCP does enter the building and does see R #2 occasionally but does not leave or provide notes of her visits.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 52443 Based on interviews, the facility failed to ensure the facility had sufficient staff to meet the needs of all 114 residents who resided in the facility when staff failed to: 1. Offer baths or showers to the residents as scheduled and per residents' preference. 2. To answer call lights within a reasonable timeframe (under 10 minutes) for residents that require activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance. These deficient practices are likely to negatively impact resident comfort. The findings are: Baths/Showers: A. Refer to F561 and F677 for related findings. B. On 04/14/25 at 2:10 pm during an interview with Certified Nursing Assistant (CNA) #2, she stated on most days she will be the only CNA on her unit and the residents do not receive showers per the shower schedule due to low staffing. C. On 04/14/25 at 4:04 pm during an interview with CNA #4, she stated this past weekend (04/12/25 through 04/13/25), she was the only CNA on her unit on Saturday and Sunday. CNA #4 confirmed residents do not receive showers per the shower schedule due to low staffing. D. On 04/14/25 at 2:10 pm during an interview with CNA #2, she stated on most days she will be the only CNA on her unit and residents do not receive showers per the shower schedule due to low staffing. E. On 04/15/25 at 10:48 am during an Interview with CNA #6, she stated I am working alone two to three days per week. She confirmed she cannot complete resident showers and other assigned duties within work shift hours. She confirmed she will work her assignment, and half of an additional CNA assignment due to low staffing F. On 04/15/25 at 2:37 pm during an Interview with Registered Nurse (RN) #1, she stated sometimes they do not have staffing, sometimes people call off and CNAs get pulled to another hall to share assignments. There should be two CNAs per hall. G. On 04/15/25 at 3:19 pm during an interview with the Unit Manager (UM) #1, he confirmed staffing issues affect residents Activities of Daily Living (ADL), which includes showers. H. On 04/16/25 at 12:50 pm during an interview with the Director of Nursing (DON), DON stated yes, we are short-staffed and have several job openings right now. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Call Lights: I. On 04/14/25 at 11:13 am during an interview with R #5, she stated she has had to wait about three hours on average for her call light to be answered, while she is in a dirty brief. R #5 stated there is not enough staff to answer call lights or provide timely care. J. On 04/14/25 at 11:45 am during an interview with R #8, she stated that at night there is only one CNA for the whole floor her room is on and she has to wait a long time for the call lights to be answered. K. On 04/14/25 at 4:04 pm during an interview with CNA #4, she stated that due to the facility not having enough staff, residents can sometimes wait up to an hour or longer to have their call lights answered. L. On 04/15/25 at 11:17 am during an interview with CNA #7, she stated that it will take her a long time to answer call lights due to the amount of CNAs available.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure medical records were updated with the post fall neurological evaluations/assessments (a thorough assessment of your nervous system, including your brain, spinal cord, and peripheral nerves) for 1 (R #4) of 1 (R #4) resident reviewed for falls. This deficient practice could likely result in staff not knowing residents' daily care events, changes, and their needs. The findings are. A. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE]. B. Record review of nursing progress notes dated 04/11/25 revealed R #4 experienced an unwitnessed fall and R #4 was found between the beds with the curtain over her head and her left leg over the bedside table leg. C. Record review of R #4's Electronic Health Record (EHR) revealed R #4's post fall neurological evaluations were not present in R #4's EHR. D. On 04/16/25 at 10:32 am during an interview with Registered Nurse (RN) #3, she stated nursing staff are to begin neurological checks (evaluations) immediately after being notified that a resident had an unwitnessed fall. RN #3 also stated the facility has a form that must be completed when each neurological evaluation has been conducted and documented. E. On 04/16/25 at 11:45 am during an interview with the Activities Aide (AA), she stated her position was in medical records prior to becoming the AA. AA further stated that she was unable to locate R #4's post fall neurological evaluations (fall on 04/10/25) in the current medical records office. F. On 04/16/25 at 1:01 pm during an interview, the Director of Nursing (DON) presented the neurological evaluations for R #4's fall on 04/10/25 and stated the documentation should have been present in R #4's EHR, and they were not.