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	06/12/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** PAST NON-COMPLIANCE Based on record review and interview, the facility failed to ensure a resident was free of accident hazards when staff failed to assist a resident who required two persons assistance and a mechanical lift (a device such as Hoyer Lift that is used to lift and move a person from on location to another) when changing positions for 1 (R #1) of 1 (R #1) resident. This failure could likely result in resident to fall and inquire injuries. The findings are: A. Record review of R #1's face sheet dated 06/16/25 revealed she was admitted to the facility on [DATE] with the following diagnoses: -Demyelinating (break down and destruction of the outer lining of nerves) Disease of Central Nervous System (the core portion of the nervous system). -Quadriplegia (paralysis-partial or complete-of the arms and legs). Anoxic (lack of oxygen) Brain Damage. B. Record review of R #1's care plan created 09/12/23, revealed R #1 was to be transferred by a mechanical lift, assisted by two persons and supervised by a nurse during all transfers. C. Record review of R #1's daily care note dated 05/20/25 at 6:27 pm revealed a notation for R #1 that indicated a change of condition due to a fall on 05/20/25. D. Record review of Nurse Practitioner (NP) contact note dated 05/22/25, revealed R #1 was seen by NP for follow-up after reporting increased left shoulder pain following a transfer into bed. NP note stated an X-ray of R #1's shoulder revealed a fracture (break) of the left shoulder. R #1 is scheduled to see orthopedics (provider who specializes in care and management of bones) the next day, 05/23/25. NP note further stated that R #1's pain is being managed with provided pain medications (note does not indicate which medications were being provided). E. Record review of the facility's completed incident report dated 05/31/25 revealed R #1 had been transferred (date not specified) by an unnamed CNA (Certified Nurses Aide) from R #1's wheelchair to her bed by lifting R #1 under her arms and transferred R #1 from her wheelchair to her bed without another staff member and without the use of a mechanical lift device. Supervision of a nurse was not present. The CNA was immediately suspended pending investigation. (continued on next page)

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

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	06/12/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. Record review of the facility's provided training documents revealed the following: -05/21/25 An audit of all residents was completed and changes made to resident care plans of all residents who required two person, mechanical lift when transferring. -05/22/25 Facility leadership staff met with and educated all staff for accurate lift transfer compliance and safe patient handling. --05/22/25 Facility leadership staff reviewed all facility available mechanical lift equipment completing an inventory of all equipment and confirming proper operation of all mechanical lift equipment. -05/23/25 Facility leadership staff provided an all staff hands on competency training to demonstrate proper use of mechanical lift equipment and to require all staff to demonstrate proper use of all mechanical lift equipment. -0523/25 Director of Nursing reviewed all staff completion of on line training for the use of mechanical lift equipment. G. On 06/11/25 at 1:13 pm during interview with R #1, she stated that she had been transferred from her wheelchair to her bed by a single CNA. R #1 stated that during this transfer, she had heard a pop and felt pain in her shoulder. She stated that she was informed that she had broken her collar bone. She stated that she had attended an office visit with an orthopedic doctor who made no recommendation for further treatment except pain medication and a sling. She stated that her pain was managed by her pain medication at the time and that she now had no pain or discomfort. R #1 stated that since the incident, she has been transferred multiple times from bed to wheelchair and back. R #1 stated that since the date, she has always been transferred by two staff using a mechanical lift and a nurse present. H. On 06/12/25 at 10:15 am during interview with CNA #1, she stated that after the incident she had attended and participated in training for the transfer of residents who require a mechanical assist. She stated she had completed on-line training, and she had completed in-person training. CNA #1 could not recall the dates when she attended in person training or when she completed on-line training. She stated she had been trained to complete all mechanical lifts with two persons and a nurse present. She stated she was aware of all residents in her area that required a mechanical lift when transferring positions. I. On 06/12/25 at 10:25 am during interview with Licensed Practical Nurse (LPN) #1, she confirmed R #1 had been dropped by a CNA who failed to use a mechanical lift. She stated this happened in late May 2025. LPN #1 stated that the CNA had been trained in-person in late May 2025 for the use of mechanical lifts and the requirement for two persons to complete any transfers when using a mechanical lift. (continued on next page)

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	06/12/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	J. On 06/12/25 at 10:45 am during interview with CNA #2, she confirmed that she had attended trainings on 05/26/25 that addressed the use of mechanical lift equipment and that she had also completed on-line trainings. She stated that all residents who required a mechanical lift assist when transferring positions were to be done with two persons present and a licensed nurse to monitor the process. She stated that she had always conducted mechanical lift transfers with two persons and that the training reconfirmed her previous training. CNA #2 stated that she was aware of each resident's needs for transfer and she knew of the residents she was assigned to, which residents required mechanical lift transfers.

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	06/12/2025

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure medications for 2 (R #2 and 3) of 3 (R #2, 3 and 9) residents were: - available in the facility to be administered to R #3, - administered at the right time 6:30 AM for R #2. These deficient practices could likely result in unresolved infections, worsening of infection or uncontrolled pain. The findings are: Medication availability A. On 06/11/25 at 1:10 PM, during an interview with R #3's daughter, she stated that her mother's hospital discharge orders indicated oral antibiotics (medicines that are taken by mouth to kill bacteria) were to be started on 05/05/25, when intravenous (IV) antibiotics (administered directly into a vein) were discontinued. However, they were not initiated until 05/07/25. She further stated that this delay was very concerning due to R #3's diagnoses of pneumonia (infection of the lungs) and sepsis (an extreme immune response to infection that can lead to tissue damage, organ failure, or death if not treated right away). B. Record review of R #3's hospital discharge orders dated 04/30/25, revealed continue IV Unasyn (medicine that is used to treat a variety of bacterial infections) 3 g (grams) q6h (every 6 hours) to complete 14 days with EOT (end of treatment) 5/4, then switch to clindamycin (medication used to treat bacterial infections) 400 mg tid (three times a day) to complete at least 3 week therapy SOT (start of treatment) 5/5 in AM (morning) C. On 06/11/25 at 2:30 PM during interview with the Director of Nursing, he confirmed R #3 was not administered the oral antibiotic as ordered because the medication had not arrived from the pharmacy. He further stated that they ordered the medication on 04/30/25 and they did not receive it in the facility until 05/07/25. Medication administration D. On 06/12/25 at 10:37 AM during an interview with R #2, she stated that pain medications were often administered late. She further explained, 'For example, this morning I should have received my pain medication at 6:30 AM, but it wasn't even offered until 8:30 AM or 9:00 AM. She added that this is something that needs to change, as she prefers to stay on schedule with her pain medication to prevent the pain from getting out of control. E. Record review of R #2's medication administration record (MAR) for June 2025 revealed R #2's first scheduled dose of pain medication was to be administered at 6:30 AM. It further revealed that R #2 received her pain medication at 3:00 AM, 9:00 AM, 3:00 PM and 9:00 PM from 05/24/25 through 06/07/25. On 06/07/25 the pain medication administration times changed to 6:30 AM, 11:30 AM, 4:30 PM and 9:00 PM. (continued on next page)

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	06/12/2025

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. Record review of physicians orders revealed R #2's pain medication was as follows: Hydrocodone-Acetaminophen Oral Tablet (medicine used to relieve moderate to severe pain) 5-325 MG (milligram, used to measure the dosage of medications), give one tablet by mouth four times a day for chronic pain. G. On 06/12/25 at 11:45 AM during an interview with Licensed Practical Nurse (LPN) #2, he stated that he was not passing medication this morning 06/12/25, but R #2 stopped him in the hallway and asked when her pain medication was going to be given to her. He further stated that they have an hour before and an hour after the scheduled time to administer medications. G. On 06/12/25 at 12:00 PM during an interview with LPN #3, she stated she had a very busy morning today 06/12/25 with two patients being sent out to the emergency room and was not able to start medication administration on time. H. On 06/12/25 at 12:21 PM during an interview with the Director of Nursing, he confirmed that pain medication for R #2 was late on 06/12/25 and should not have been.