

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/22/2026
NAME OF PROVIDER OR SUPPLIER Skies Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for 1 (R #1) of 3 (R #1, #2 and #3) resident, when: The facility failed to ensure R #1 continued to receive sliding scale insulin immediately after he returned from a hospitalization. If the facility fails to obtain and verify appropriate medication orders for a resident with a history of consistently receiving sliding scale insulin, then residents are likely to experience poorly controlled blood glucose (sugar) levels, worsening symptoms, disease progression, and avoidable complications. The findings are: A. Record review of R #1's face sheet revealed R #1 was admitted to the facility on [DATE] with type 2 diabetes mellitus (DM2; a disease in which the body cannot make or properly use insulin) with diabetic neuropathy (a type of nerve damage that occurs as a complication with diabetes) and was discharged on 12/31/25. B. Record review of R #1's nursing progress notes, dated 10/27/25, revealed R #1 was sent to the hospital for respiratory distress. C. Record review of R #1's hospital physician orders, dated 10/27/25, revealed R #1 received insulin Lispro-U 100 (HumaLog; a rapid-acting insulin used to control blood sugar) while in the hospital. D. Record review of R #1's physician orders, dated 07/17/25 through 11/25/25 revealed the following: Dated 07/17/25, Insulin Lispro (1 unit dial) subcutaneous (under the skin) solution pen-injector 100 unit/mL (milliliter). Inject as per sliding scale subcutaneously before meals and at bedtime for Diabetes Mellitus 2 (if the blood sugar (glucose) level is 201 to 250 administer 4 units; if the blood sugar level is 251 to 300 administer 6 units; if the blood sugar level is 301 to 350 administer 8 units; if the blood sugar level is 351 to 400 administer 10 units; if the blood sugar is 401 to 450 administer 12 units). This medication was discontinued on 10/13/25. Dated 10/14/25, Insulin Lispro (1 unit dial) subcutaneous (under the skin) solution pen-injector 100 unit/mL (milliliter). Inject as per sliding scale subcutaneously before meals and at bedtime for Diabetes Mellitus 2 (if the blood sugar level is 201 to 250 administer 4 units; if the blood sugar level is 251 to 300 administer 6 units; if the blood sugar level is 301 to 350 administer 8 units; if the blood sugar level is 351 to 400 administer 10 units; if the blood sugar is 401 to 450 administer 12 units). This medication was discontinued on 10/25/25. Dated 11/10/25, blood Sugar Checks before meals and at bedtime for diabetes mellitus management. Dated 11/25/25, Empagliflozin (an antidiabetic medication used to improve glucose control) oral tablet, 10 milligrams (mg). Give 1 tablet by mouth in the morning for low blood sugar. This medication was discontinued on 12/22/25. R #1's insulin was not continued by the facility staff when he returned to the facility on [DATE] at 11:11 pm. E. Record review of R #1's Quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 11/29/25, revealed R #1 has an active diagnosis of diabetes mellitus. F. Record review of R #1's physician orders, dated 12/19/26 through 01/09/26, revealed the following: Dated 12/19/25, HumaLog Injection Solution (Insulin Lispro) 100 Unit/mL. Inject subcutaneously per sliding scale before meals and at bedtime for Diabetes Mellitus 2 (if the blood sugar level is 201 to 250 administer 4 units; if the blood sugar level is 251 to 300 administer 6 units; if the blood sugar level is 301 to 350 administer 8 units; if the blood sugar level is 351 to 400 administer 10 units). This medication was discontinued on 12/22/25. Dated 12/22/25, HumaLog KwikPen (insulin) subcutaneous solution pen-injector 100 (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unit/mL. Inject subcutaneously as per sliding scale before meals and at bedtime for Diabetes Mellitus 2 (if the blood sugar level is 201 to 250 administer 4 units; if the blood sugar level is 251 to 300 administer 6 units; if the blood sugar level is 301 to 350 administer 8 units; if the blood sugar level is 351 to 400 administer 10 units; if the blood sugar is 401 to 450 administer 12 units). This medication was discontinued on 01/09/26. Dated 12/23/25, Empagliflozin oral tablet, 25 mg. Give 25 mg by mouth one time a day for diabetes. G. Record review of R #1's Medication Administration Record (MAR), dated 11/04/25 through 12/19/25, revealed R #1 did not receive any sliding scale insulin for seventy-five (75) documented blood glucose readings over 200, thirty-six (36) blood glucose readings over 300, and two (2) blood glucose readings over 400. H. Record review of R #1's care plan, dated 12/07/25, revealed R #1 was diagnosed with insulin-dependent diabetes. I. Record review of R #1's electronic health record (EHR), dated 06/15/26, revealed the facility nursing staff did not contact the hospital or the facility provider when R #1 returned to the facility on [DATE] without physician orders for insulin use, even though R #1 had been administered insulin before discharge to the hospital on [DATE]. J. On 06/15/26 at 3:00 PM, during an interview, the Director of Nursing (DON) stated when a resident is newly admitted or re-admitted, the floor nurse is responsible for obtaining the hospital discharge orders, reviewing them, and clarifying or clearing them with the facility on-call provider. She stated physician orders are reconciled during the facility's daily clinical meeting as a secondary check, and the pharmacy completes a medication review for all new admissions within 24 hours. The DON stated facility nurses are expected to call and verify orders if any questions arise or if a critical medication, such as sliding scale insulin, is omitted (left out or excluded) when a resident previously received it. The DON stated R #1 should have continued to receive insulin in the facility prior to 12/19/25, but he did not. K. On 06/22/26 at 11:07 am, during an interview, the Medical Director (MD) stated she expects a physician to be notified immediately whenever a resident's blood glucose level exceeds 400 to ensure diabetes is properly controlled. The MD stated R #1 fell through the cracks upon re-admission, and R #1 should have been receiving regular blood sugar checks and insulin when he returned to the facility on [DATE], but he did not.		

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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** Based on observation, record review, and interviews, the facility failed to ensure the environment was free of accident hazards for 1 (R #4) of 2 (R #'s 3 and 4) resident, when the facility staff failed to: Use two staff members to safely transfer R #4 with a Hoyer lift (equipment used to move residents who have limited mobility) as required. This deficient practice is likely to result in residents getting injured in avoidable accidents and putting residents at risk of serious injury and harm. The findings are: A. Record review of the facility's Safe Resident Handling/Transfer Equipment, reviewed on 06/16/26, revealed the following: Safe resident handling involves the use of assistive devices to ensure that patients can be transferred safely and that care providers avoid performing high risk patient handling tasks. Patients will be assessed upon admission and on an ongoing basis to determine the patient's ability to transfer and reposition and the need for safe resident handling equipment. Staff will complete training and demonstrate competency in the use of safe resident handling equipment. Manufacturers' instructions will be used for all safe resident handling equipment. Two trained persons are required to operate a total lift (support patients who cannot stand or bear weight independently) or sit to stand lift (assist patients who can bear some weight and participate in standing), regardless if manufacturer instructions state only one person is needed. No one under the age of eighteen may operate a mechanical lift. The purpose is to optimize staff safety and the safety, comfort, and function of patients during transfers, ambulation, and/or repositioning. B. Record review of R #4's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 05/10/26, revealed R #4 was admitted into the facility on [DATE] and was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) for transfers. C. Record review of R #4's care plan, dated 05/21/26, revealed R #4 required transfer assistance with a mechanical lift, provided by two Certified Nursing Assistants (CNAs), with nurse monitoring. D. On 06/16/26 at 11:35 am, during an observation, the Activities Assistant (AA) was observed placing a Hoyer lift sling under R #4 before the transfer. The AA then closed R #4's door and transferred R #4 without additional staff assistance. E. On 06/16/26 at 11:43 am, during an interview, the AA stated she used the Hoyer lift to transfer and reposition R #4. She stated she knew it was wrong to use the Hoyer lift alone and acknowledged it was unsafe to transfer a resident using the Hoyer lift without another staff member's assistance. F. On 06/16/26 at 2:55 pm, during an interview, the Director of Nursing (DON) stated her expectation is for staff to follow safety guidelines when transferring a resident who requires a Hoyer lift. The DON stated a Hoyer lift requires two staff members to provide the safest mechanical transfer for a resident and to maintain staff safety. She stated the facility staff should never transfer a resident alone while using a Hoyer lift.		