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Form Approved OMB
No. 0938-0391

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	01/08/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to promote care with dignity and respect for 1(R #22) of 9(R #1, R #6, R #11, R #22, R #28, R #35, R #41, R #64 and R #71) residents reviewed for dignity and respect by not knocking on R#22's door before entering room. This deficient practice is likely to impact residents' dignity and respect for their personal space.The findings are: A. On 01/04/26 at 8:40 am, during a random observation of the 400-hall, Registered Nurse (RN) #5 walked straight into R #22's room without knocking or announcing himself to R #22. B. On 01/04/26 at 8:42 am, during an interview with RN #5, he confirmed that he should have knocked and announced himself prior to entering R #22's room.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (group of drugs that affect behavior, mood, thoughts, or perception) unless the medication was medically necessary for 2 (R #11 and R #63) of 3 (R #11, R #63, R #109) residents reviewed for unnecessary medications, when staff failed to ensure psychotropic medications were necessary to treat a specific condition as diagnosed and documented in the clinical record. This deficient practice could likely lead to adverse drug effects and poor patient outcomes.The findings are: R#11 A. Record review of R #11's admission Record revealed R #11 was admitted to the facility on [DATE] with the following diagnoses:1. End stage renal disease (final stage of chronic kidney disease, where the kidneys can no longer function adequately, requiring dialysis or a kidney transplant for survival),2. Dependence on renal dialysis (medical procedure used to remove waste products and excess fluid from the blood when the kidneys are no longer able to perform this function effectively),3. Paranoid schizophrenia (a false belief or judgement about external reality, held despite incontrovertible evidence to the contrary, as a symptom of serious mental illness),4. Bipolar disorder (mental health condition characterized by extreme mood swings, including emotional highs and lows, which can significantly impact daily life),5. Presbyopia (gradual loss of your eyes' ability to focus on nearby objects),6. Post-traumatic stress disorder (mental health condition that's caused by an extremely stressful or terrifying event or either being part of it or witnessing it).B. Record review of R #11's physician orders revealed an order for Citalopram Hydrobromide (anti-depressant medication) oral tablet 10 milligrams (MG). Give 10 MG by mouth at bedtime for depression. Start date 09/25/25.C. On 01/08/26 at 11:47 am, during an interview with the Interim Director of Nursing (IDON) she confirmed the following:1. The indicated use of Citalopram Hydrobromide is depression,2. R #11 does not have a diagnosis for depression,3. Medications should be documented to treat specific conditions as diagnosed and these were not. R #63D. Record review of R #63's admission record revealed R #63 was admitted to the facility on [DATE] with the following diagnoses:1. Lymphedema (chronic swelling),2. Chronic pain,3. Bi-polar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),4. Adjustment disorder (a strong emotional or behavioral reaction to a specific, identifiable stressor),5. Hypothyroidism (the thyroid is not making enough thyroid hormone). E. Record review of R #63's physician orders revealed the following:1. An order for Fluoxetine Hydrochloride (HCl) (Anti-depressant medication) oral tablet 20 milligrams (MG). Give 20 MG by mouth one time a day for depression. Start date 01/07/26. 2. An order for Venlafaxine HCl (Anti-depressant medication) oral tablet 75 MG. Give 75 MG by mouth one time a day for depression. Start date 01/06/26.3. An order for Trazodone HCl (Anti-depressant medication) oral tablet 150 MG. Give 2 tablets by mouth at bedtime for insomnia. Start Date 12/24/25. F. On 01/08/26 at 11:47 am, during an interview with the IDON, she confirmed the following:1. R #63's indicated use for Fluoxetine and Venlafaxine is depression.2. R #63's indicated use for Trazadone is insomnia.3. R #63 does not have diagnosis for depression or insomnia.4. Medications should be documented to treat specific conditions as diagnosed and these were not.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to complete an accurate Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessment for 4 (R #13, R #63, R #71 and R #94) of 5 (R #13, R #63, R #71, R #94 and R #109) resident reviewed for assessments. This deficient practice could likely result in the residents' preferences and care needs not being met. The findings are:R #13 A. Record review of R #13's admission Record revealed she was originally admitted to the facility on [DATE]. B. Record review of R #13's physician's order dated 12/22/25 revealed R #13 was scheduled to see an audiologist (a healthcare professional who specializes in hearing and balance disorders) for unspecified hearing loss. C. Record review of R #13's care plan dated 11/28/25 revealed R #13 has impaired communication as evidenced by impaired hearing. D. Record review of R #13's MDS assessment dated [DATE] section B, revealed R #13 has adequate hearing and requires no hearing aids. E. On 01/08/26 at 10:46 am, during an interview with the MDS coordinator, she confirmed R #13 is hard of hearing and the MDS assessment 12/06/25 was documented incorrectly. R #63 F. Record review of R #63's admission record revealed R #63 was admitted to the facility on [DATE]. G. Record review of R #63's physician record revealed an order for Pregabalin (anti-convulsant medication) oral capsule 50 milligrams (MG). Give 50 MG by mouth two times a day for chronic pain syndrome. Start Date 12/19/25. H. Record review of R #63's MDS assessment dated [DATE] Section N revealed, R #63 does not take anticonvulsants. I. On 01/08/26 at 10:46 am, during an interview with the MDS coordinator, she confirmed R #63 does take an anticonvulsant medication. The medication should be included in the MDS assessment and was not. R #71 J. Record review of R #71's admission Record revealed R #71 was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic obstructive pulmonary disease with (acute) exacerbation (symptoms including shortness of breath, quantity and color of phlegm that typically lasts for several days), (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Vascular dementia (changes in thinking and memory that occur when there isn't enough blood flow to part of the brain), 3. Dysphagia, oropharyngeal phase (a disorder or impairment in initiating a swallow), 4. Crohn's disease (type of inflammatory bowel disease that causes swelling and irritation of the tissues, called inflammation, in the digestive tract. This can lead to belly pain, severe diarrhea, fatigue, weight loss and malnutrition), 5. Insomnia (sleep disorder that can make it hard to fall asleep or stay asleep). K. Record review of R #71's MDS assessment dated [DATE] section O revealed R #71 does not use a Continuous Positive Airway Pressure (CPAP) machine (a medical device that delivers pressurized air through a mask to keep your airway open during sleep). L. Record review of R #71's hospital after-visit summary dated 02/23/25 revealed R #71 was discharged from hospital with a CPAP machine. M. On 01/04/26 at 11:58 am, an observation and interview with R #71 in his room revealed a CPAP machine next to R #71's bed. R#71 stated he does use his CPAP machine every night and has since his admission to facility. N. On 01/08/26 at 11:45 am, during an interview with the Interim Director of Nursing (IDON), she confirmed the CPAP machine was not included in R #71's MDS assessment and stated it should be included in the MDS assessment. R #94 O. Record review of R #94's admission Record revealed she was originally admitted to the facility on [DATE]. P. Record review of R #13's care plan dated 11/14/25 revealed R #94 has impaired communication as evidenced by difficulty making self-understood (expressive) due to garbled speech and Cerebral Palsy (a neurological condition that can present as issues with muscle tone, posture and/or a movement disorder). Q. Record review of R #13's MDS assessment dated [DATE] section B, revealed R #94 has clear speech. R. On 01/08/26 at 10:451 am, during an interview with the MDS coordinator, she confirmed R #94 has speech impairment and the MDS assessment dated [DATE]was documented incorrectly.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the PASARR (Preadmission Screening and Resident Review) Level I Identification Screen accurately reflected the resident's diagnosis for 1 (R #12) of 2 (R #11 and R #12) residents reviewed for accuracy of PASARR screening. If the facility does not ensure PASARR screenings are completed accurately, then residents with serious mental illness may not receive required evaluations or specialized services, placing them at risk for unmet mental health needs and a decline in psychosocial well-being.The findings are:A. Record review of R #12's admission record revealed R #12 was admitted into the facility on [DATE] with the following diagnoses:1. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),2. Prolonged grief disorder (a mental health condition characterized by intense and persistent grief that significantly impairs daily functioning, lasting longer than culturally expected after the loss of a loved one), 3. Post-Traumatic Stress Disorder (PTSD; a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety),4. Alcohol dependence (a serious condition characterized by a strong, uncontrollable desire to drink),5. Insomnia (sleep disorder that can make it hard to fall asleep or stay asleep).B. Record review of R #12's PASARR Level I Identification Screening, dated 10/23/25, revealed the resident did not have a diagnosis of or a suspected mental illness. C. On 01/08/26 at 11:50 am, during an interview with the Interim Director of Nursing, she confirmed R #12's PASARR did not accurately reflect R #12's diagnoses.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 1 (R #21) of 2 (R #12 and R #21) residents reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are: A. Record review of R #21's admission record revealed R #21 was admitted into the facility on [DATE] with the following diagnoses:1. Pancytopenia (serious blood condition where there's a lower-than-normal count of all three blood cell types: red blood cells, white blood cells, and platelets, leading to fatigue, infection risk, and bleeding),2. Small B-cell lymphoma (slow-growing cancers in fully grown white blood cells that form the backbone of the immune system),3. Nontraumatic intracerebral hemorrhage (ICH; bleeding directly into the brain tissue),4. Cognitive Communication Deficit (difficulty speaking, listening, reading, or writing due to underlying thinking problems like poor memory, attention, problem-solving, or social understanding),5. Anemia (a condition where the blood lacks enough healthy red blood cells, reducing oxygen delivery to the body, causing fatigue, weakness, paleness, and shortness of breath, often due to iron/vitamin deficiencies, blood loss, chronic diseases, or inherited disorders like sickle cell anemia).B. Record review of R #21's hospital discharge orders dated 12/17/25 revealed a diagnosis of Multidrug-Resistant Organism (MDRO; a germ that is resistant to many antibiotics).C. Record review of R #21's Electronic Health Record revealed an alert for infection prevention and control with an onset date of 12/17/25 for wound and Escherichia coli (E-Coli; a bacteria that lives in the intestines) MDRO.D. Record review of R #21's baseline care plan dated 12/18/25 revealed the following:1. No interventions for MDRO was included in his care plan.2. No interventions for the use Modified Protective Environment Precautions (a facility policy with special instructions to protect residents in their environment) were included on his care plan.E. On 01/04/26 at 11:43 am, during a random observation of the 100-hall, revealed R #21 had a sign next to his door for Modified Protective Environment Precautions.F. On 01/07/26 at 8:32 am, during an interview with the infection prevention coordinator (IPC), she confirmed R #21 has a diagnosis of MDRO. She stated that R #21 is on Modified Protective Environment Precautions as an alternative for neutropenic precautions (a set of infection control measures for people with a low neutrophil count, which increases their susceptibility to infection). G. On 01/08/26 at 11:50 pm, during an interview with the Interim Director of Nursing, she confirmed R #21 does not have interventions for MDRO and the need for Modified Environment Precautions on his care plan and should.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop and implement an accurate, comprehensive care plan for 3 (R #21, R #63 and R #71) of 4 (R #12, R #21, R #63, and R #71) residents reviewed for care plans when staff failed to: 1. Develop a care plan to include interventions for R #21's diagnosis of Multidrug-Resistant Organism (MDRO; a germ that is resistant to many antibiotics),2. Develop a care plan to include interventions for R #21's need for Modified Protective Environment Precautions, (a facility policy with special instructions to protect residents in their environment).3. Develop a care plan for R #63's use of bed rails.4. Develop a care plan for R #71's use of Continuous Positive Airway Pressure Machine (CPAP; a medical device that delivers pressurized air through a mask to keep your airway open during sleep). This deficient practice could likely result in proper care not being provided to residents.The findings are: R #21 A. Record review of R #21's admission record revealed R #21 was admitted into the facility on [DATE] with the following diagnoses: 1. Pancytopenia (serious blood condition where there's a lower-than-normal count of all three blood cell types: red blood cells, white blood cells, and platelets, leading to fatigue, infection risk, and bleeding), 2. Small B-cell lymphoma (slow-growing cancers in fully grown white blood cells that form the backbone of the immune system), 3. Nontraumatic intracerebral hemorrhage (ICH; bleeding directly into the brain tissue), 4. Cognitive communication deficit (difficulty speaking, listening, reading, or writing due to underlying thinking problems like poor memory, attention, problem-solving, or social understanding), 5. Anemia (a condition where the blood lacks enough healthy red blood cells, reducing oxygen delivery to the body, causing fatigue, weakness, paleness, and shortness of breath, often due to iron/vitamin deficiencies, blood loss, chronic diseases, or inherited disorders like sickle cell anemia). B. Record review of R #21's hospital discharge orders dated 12/17/25 revealed a diagnosis of Multidrug-Resistant Organism (MDRO; a germ that is resistant to many antibiotics). C. Record review of R #21's Electronic Health Record revealed an alert for infection prevention and control with an onset date of 12/17/25 for the following diagnoses: wound and Escherichia coli (E-Coli; a bacteria that lives in the intestines) MDRO. D. Record review of R #21's care plan dated 12/18/25 revealed the following: 1. No interventions for MDRO were included in his care plan. 2. No intervention for the use of Modified Protective Environment Precautions were included in his care plan. E. On 01/04/26 at 11:43 am, during a random observation of the 100-hall revealed R #21 had a sign (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	next to his door for Modified Protective Environment Precautions. F. On 01/07/26 at 8:32am during an interview with the Infection Prevention Coordinator (IPC), she confirmed R #21 has a diagnosis of MDRO. She stated R #21 is on Modified Protective Environment Precautions as an alternative for neutropenic precautions (a set of infection control measures for people with a low neutrophil count, which increases their susceptibility to infection). G. On 01/08/26 at 11:50 am, during an interview with the Interim Director of Nursing (IDON), she confirmed R #21 does not have interventions for MDRO and the need for Modified Environment Precautions in his care plan and should. R #63 H. Record review of R #63's admission record revealed R #63 was admitted on [DATE] with the following diagnoses: 1. Lymphedema (chronic swelling), 2. Chronic pain, 3. Bi-polar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), 4. Adjustment disorder (a strong emotional or behavioral reaction to a specific, identifiable stressor), 5. Hypothyroidism (the thyroid is not making enough thyroid hormone). I. Record review of R #63's physician orders revealed an order please place assist/side rails x (times) 2. Start date 12/19/25. J. Record review of R #63's care plan dated 12/20/25 revealed there was no intervention for the use of side rails. K. On 01/04/26 at 1:26 pm during a random observation of R #63's room revealed quarter size bed rails on the upper right and left sides of bed. L. On 01/04/26 at 1:27 pm during an interview with R #63 she confirmed she uses the side rails for mobility and repositioning herself. M. On 01/08/26 at 11:50 am, during an interview with the IDON, she confirmed R #63's care plan should include the use of side rails and does not. R #71 N. Record review of R #71's admission Record revealed R #71 was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic obstructive pulmonary disease with (acute) exacerbation (symptoms including shortness of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	breath, quantity and color of phlegm that typically lasts for several days), 2. Vascular dementia (changes in thinking and memory that occur when there isn't enough blood flow to part of the brain), 3. Dysphagia, oropharyngeal phase (a disorder or impairment in initiating a swallow), 4. Crohn's disease (type of inflammatory bowel disease (IBD) that causes swelling and irritation of the tissues, called inflammation, in the digestive tract. This can lead to belly pain, severe diarrhea, fatigue, weight loss and malnutrition), 5. Insomnia (sleep disorder that can make it hard to fall asleep or stay asleep). O. On 01/04/26 at 11:58 am during an observation and interview with R #71in his room, revealed a CPAP machine next to R #71's bed. R #71 he stated he does use his CPAP machine every night since admission to facility. P. Record review of R #71's care plan dated 03/29/25 revealed no interventions for the use of Continuous Positive Airway Pressure (CPAP) machine (a medical device that delivers pressurized air through a mask to keep your airway open during sleep). Q. On 01/08/26 at 11:51 am during an interview with IDON, she confirmed the facility failed to develop and implement a care plan that includes R #71's use of CPAP machine. The IDON stated that she expects residents to have a care plan that includes all required interventions including the use of CPAP machines.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, the facility failed to provide quality care that meets professional standards for 1 (R #100) of 1 (R #100) resident reviewed when the staff failed to follow physician orders. This deficient practice is likely to result in residents not maintaining their optimal health as planned by their medical provider. The findings are: A. Record review of R #100's physician's order dated 11/04/25 revealed an order of Rybelsus (prescription medication used to treat type 2 diabetes [DM2; a disease in which the body cannot make or properly use insulin]) tablet 7 Milligrams (mg), Give 7 mg by mouth one time a day, take 30 mins before food/drink.B. On 01/06/26 at 8:41 am, during an observation of medication administration, Licensed Practical Nurse (LPN) #2 administered the medication while R #100 is finishing his breakfast.C. On 01/06/26 at 8:43 am, during an interview with LPN #2, she stated that she did know it should be given 30 mins before any food or drink.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on record review and interview, the facility failed to ensure 1 (R #5) of 1 (R #5) resident is receiving restorative services (services necessary to ensure the resident's abilities are not diminished). If the facility is not ensuring residents receive restorative services at the commencement of therapy services when indicated, residents are likely to experience a decrease in their activities of daily living. The findings are: A. On 01/05/26 at 6:10 pm during an interview with R #5, she stated she would like to get some kind of therapy even if it's just restorative therapy. B. On 01/07/26 at 1:00 pm during an interview with Physical Therapist (PT), he confirmed R #5 was discharged from therapy but could not remember the date and should be receiving restorative therapy. C. Record review of R #5's physician orders dated 12/23/25 revealed R #5 was referred to restorative nursing program (RNP) to receive the service three times a week for improved quality of life.D. Record review of R #5's restorative therapy notes did not indicate that R #5 was receiving restorative services. E. On 01/09/26 at 9:15 am during interview with Restorative Aide (RA), she stated when physical therapy discharges a resident, they are supposed to notify her and confirmed she was not notified about R #5's order for restorative program.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide restorative physical therapy service devices as recommended by the therapy department for 1 (R #5) of 1 (R #5) residents. This deficient practice is likely to result in residents having pain and a decrease in mobility, causing psychosocial harm and despair. The findings are: A. Record review of R #5's face sheet revealed R #5 was admitted into the facility on [DATE] with the following diagnoses: Non-active primary progressive multiple sclerosis (MS: where symptoms worsen without relapses or new MRI (new or enlarging lesions seen on MRI scans, or lesions that enhance with contrast, showing ongoing inflammation in the central nervous system), Delusional disorders (a delusional disorder is when someone has a fixed false belief that doesn't change with evidence), Tremors unspecified (unspecified means involuntary shaking where the exact type or cause isn't identified), Uninhibited neurogenic bladder (the bladder contracts too often due to a nerve problem, but the exact type isn't classified),Other nonrheumatic mitral valve disorder (means mitral valve problems not caused by rheumatic disease that don't fit a more specific category). B. Record review of R #5's care plan, dated 12/13/25, revealed R #5 required assistance to meet basic activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) care due to MS to include assistance with transfers and ensuring R #5's call light was in reach for use. C. On 01/05/26 6:10 pm, during an observation and interview with R #5, she lay in bed with her head positioned near her left shoulder and visible contractures (muscle tightening deformity that makes flexibility and movement difficult) of both of hands. R #5 stated she thought she was supposed to receive range of motion exercises from the restorative program. She stated she did not receive it, but she would like to. D. On 01/06/26 at 9:15am during an interview with Activity Director (AD), she stated she was responsible for doing the restorative nursing program and she did not offer range of motion or restorative nursing services to R #5.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a resident with a foley catheter (a flexible, tube-like medical device inserted into the bladder to drain urine) had an order that demonstrated that a catheter was necessary, what type of catheter was needed, and how to care for the catheter for 1 (R #63) of 1 (R #63) resident reviewed for catheter use. This deficient practice could likely result in an increased and unnecessary risk of infections for residents. The findings are: A. Record review of R #63 admission record revealed R #63 was admitted on [DATE] with the following diagnoses:1. Lymphedema (chronic swelling),2. Chronic pain,3. Bi-polar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),4. Adjustment disorder (a strong emotional or behavioral reaction to a specific, identifiable stressor),5. Hypothyroidism (the thyroid is not making enough thyroid hormone).B. Record review of R #63 physician orders revealed there were no orders for the use of foley catheter or the required catheter care.C. Record review of R #63's Minimum Data Set (MDS; a federally mandated comprehensive assessment completed by facility staff) dated 12/25/25 revealed Section H, R #63 has a catheter. D. Record review of R #63's care plan dated 12/19/25 revealed R #63 requires a foley catheter due to skin impairment E. On 01/04/26 at 12:01 pm, during a random observation of R #63's room revealed R #63 had a tube that connected to a bag with what appeared to be urine hanging from her bed. F. On 01/04/26 at 1:27 pm during an interview with R #63 she confirmed she uses a foley catheter G. On 01/08/26 at 11:50 am, during an interview with the Interim Director of Nursing, she confirmed R #63's did not have orders for the use of foley catheter or catheter care and should.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide respiratory care in accordance with professional standards for 5 (R #20, R #35, R #41, R #71, and R #109) of 6 (R #20, R #35, R #41, R #63, R #71, and R #109) residents reviewed for respiratory care when the facility failed to:1. Ensure medical orders include the amount of oxygen (a specific flow rate; measurement of the volume of liquid or gas moving per unit of time) for R #20 and R #35.2. Ensure a medical order was in place for R #41's supplemental oxygen (extra oxygen required to support the body's vital functions) use. 3. Ensure medical orders, care plan and MDS (Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) were in place and accurate for R #71's use of a continuous positive airway pressure (CPAP; a breathing therapy device used to deliver a steady stream of oxygen through a mask) machine.4. Ensure medical orders indicated when to administer R #109 oxygen and the prescribed flow rate needed.These deficient practices are likely to result in residents receiving too much or not enough oxygen and can lead to worsening of their conditions. The findings are: R #20 A. Record review of R #20's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Spastic quadriplegic (paralysis of all four limbs) cerebral palsy (a disorder of movement, muscle tone, and posture), 2. Chronic respiratory failure (a condition where the lungs cannot adequately exchange oxygen and carbon dioxide) with hypoxia (low levels of oxygen in body tissues), 3. Dependence on supplemental oxygen, 4. Epilepsy (a seizure disorder). B. On 01/04/26 at 1:48 pm during an observation of R #20 in her room, she was observed lying in her bed wearing a nasal cannula (a medical device used to deliver supplemental oxygen through their nostrils) that was connected to an oxygen concentrator (a medical device that concentrates oxygen and delivers it to someone that needs supplemental oxygen) that was located next to her bed. C. Record review of R #20's current medical orders revealed an order dated 03/21/23 for R #20 to use oxygen at one to six liters per minute via (by way of) nasal cannula continuously. D. Record review of R #20's care plan revised on 06/14/25 revealed R #20 is to have oxygen as ordered. E. On 01/08/26 at 11:45 am, during an interview with the Interim Director of Nursing (IDON), she confirmed that R #20's order for oxygen use does not specify the exact amount of oxygen (liter and flow rate) that R #20 needs. R #35 F. Record review of R #35's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs), 2. Iron deficiency anemia (Anemia is a condition in which the blood doesn't have enough healthy red blood cells. Red blood cells carry oxygen to the body's tissues), 3. Chest pain, 4. Muscle weakness, 5. Peripheral vascular disease (slow and progressive disorder of the blood vessels. Narrowing, blockage, or spasms in a blood vessel). G. On 01/04/26 at 11:50 am, an observation of R #35 in his room revealed R #35 wearing a nasal cannula that was attached to the oxygen concentrator that was located next to his bed. H. Record review of R #35's current medical orders revealed an order dated 03/29/25 for R #35 to utilize three to four liters of oxygen per minute via nasal cannula. I. On 01/08/26 at 11:47 am during an interview with the director of Nursing (IDON). She confirmed the order for R #35 does not specify the exact amount of oxygen (liters and flow rate) that R #35 should be on. R #41 J. Record review of R #41's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Pneumonia (infection that inflames the air sacs in one or both lungs), 2. Chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs), 3. Pulmonary hypertension due to lung diseases and hypoxia (chronic lung conditions and low oxygen levels), 4. Chronic kidney disease, stage 2 (mild kidney damage). 5. Iron deficiency anemia (Anemia is a condition in which the blood doesn't have enough healthy red blood cells. Red blood cells carry oxygen to the body's tissues). K. On 01/05/26 at 12:50 pm, an observation of R #41 in her room revealed R #41 wearing a nasal cannula that was connected to an oxygen concentrator that was located next to the bed. L. Record review of R #41's physician record revealed there were no orders for use of oxygen or oxygen device care. M. Record review of R #41's Care plan dated 3/25/25 revealed the following: 1. R #41 is at risk for respiratory complications related to COPD. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. O2 as ordered. N. On 01/08/26 at 11:47 am during an interview with the Director of Nursing (DON), she confirmed R #41 did not have an order for use of oxygen and should have. R #71 O. Record review of R #71's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic obstructive pulmonary disease (COPD; lung disease) with exacerbation, 2. Vascular dementia (a type of dementia that results from conditions that damage blood vessels and block blood flow to the brain), 3. Acute and chronic respiratory failure with hypoxia (long-term respiratory failure that could occur suddenly leading to low oxygen levels in the body's tissue), 4. Obstructive sleep apnea (sleep disorder that occurs when a person's breathing is interrupted during sleep), 5. Pneumonia (infection and inflammation of the lung). P. On 01/04/26 at 11:58 am, an observation and interview of R #71 in his room revealed the following: 1. A continuous positive airway pressure (CPAP; a therapy device that delivers a steady stream of sir through a mask) machine connected to a medical stand located next to R #71 bed. 2. R #71 stated the was sent to the facility with the CPAP and that he uses the CPAP every night. Q. Record review of R #71's discharge documentation from a hospital dated 02/03/25 revealed the following: 1. R #71's primary diagnosis was acute and chronic respiratory failure with hypoxia. 2. The use of a CPAP was ordered. R. Record review of R #71's MDS (Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 12/02/25 revealed R #71 does not utilize a non-invasive ventilator (CPAP) machine. S. Record review of R #71's care plan dated 03/29/2025 revealed the care plan does not include the use of a CPAP machine. T. Record review of R #71'a physician orders revealed no current order for the use of the CPAP machine. U. On 01/08/26 at 11:50 am during an interview with the Director of Nursing (DON), she confirmed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the following: 1. R #71 does utilize a CPAP machine. 2. R #71 should have an order in place for the use of the CPAP machine. 3. The use of the CPAP should be included in his care plan. 4. The use of the CPAP should be indicated in his MDS assessment. 5. The DON stated that the order, the MDS assessment, and the care plan should be accurate according to the resident's needs and confirmed R #71's is not. R #109 V. Record review of R #109's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), 2. Mild intermittent asthma (a condition that causes airways to swell making it hard to breathe), 3. Permanent atrial fibrillation (an irregular heart rhythm), 4. Obstructive sleep apnea (a disorder where muscles in the throat relax, making breathing difficult or stops breathing), 5. Presence of cardiac pacemaker (a device surgically implanted in the body to deliver electrical pulses to the heart to help the heartbeat in a regular rhythm). W. On 01/05/26 at 10:10 am during an observation of R #109 in her room, she was wearing a nasal canula that was connected to a portable oxygen concentrator that was attached to the back of her wheelchair. X. Record review of R #109's current medical orders revealed the following: 1. An order dated 12/31/25, to wear oxygen at one to five liters via nasal cannula continuously. 2. An order dated 12/31/25, to have oxygen on at one to five liters via nasal cannula as needed. Y. On 01/08/26 at 11:51 am, during an interview with the IDON, she confirmed the order for R #109's does not specify the amount of oxygen R #109 needed and whether he needed continuous or PRN (as needed) oxygen.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to obtain appropriate physician orders and complete assessments prior to installation of bed rails for 1 (R #118) of 2 (R #63 and R #118) residents reviewed for bed rails. This deficient practice could result in the physician and the resident not knowing the needs, risks and benefit of bed rails. The findings are: A. Record review of R #118's admission record revealed R #118 was admitted into the facility on [DATE]. B. Record review of R #118's physician orders revealed there is no order for use of bed rails.C. Record review of R #118's bed rail assessment dated [DATE] revealed R #118 does not need use of bed rails. D. Record review of R #118's baseline care plan dated 01/03/26 revealed there were no interventions for use of bed rails or mobility enablers. E. On 01/04/26 at 1:11 pm during a random observation of R #118's room revealed quarter size bed rails on the upper right and left sides of bed. F. On 01/04/26 at 1:12 pm during an interview with R #118, he confirmed he uses the side rails for mobility and repositioning himself. G. On 01/08/26 at 11:50 am, during an interview with the Interim Director of Nursing (IDON), she confirmed the following:1. R #63 physician orders does not include the size of bed rails and indication of use (reason for use) and should.2. R #118 does not have physician orders for use of bed rails and should prior to installation.3. R #118 assessment does not include the need for bed rails and should be prior to installation.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure 2 (NAIT #1 and NAIT #2) of 5 (NAITs #1, #2, #3, #4, and #5) Nurse Aides in Training completed a Nurse Aide Training and Competency Evaluation Program (NATCEP) or a Competency Evaluation Program (CEP) within four months of being employed at the facility. This deficient practice is likely to affect all 109 residents residing at the facility by allowing untrained staff to provide direct care to residents.The findings are:NAIT #1A. Record review of NAIT #1's personnel record reviewed the following:1. NAIT #1's hire date was 10/09/24.2. NAIT #1 is scheduled to complete her certified nursing aide test on 01/31/26 for certification.B. Record review of NAIT #1's timesheet revealed NAIT #1 worked a total of 151 shifts between 01/01/25 and 12/31/25.C. On 01/08/26 at 1:13 pm, during an interview with the Administrator (ADM), she confirmed NAIT #1 has not yet received her certification and continued to work shifts during that time. She stated her expectation is for all nurse aids to become certified within four months. NAIT #2D. Record review of NAIT #2's personnel record reviewed the following:1. NAIT #2's hire date was 06/29/25.2. NAIT #2's is scheduled to complete her CNA test on 01/31/26 for certification.E. Record review of NAIT #2's timesheet revealed NAIT #2 worked a total of 57 shifts between 08/01/25 and 12/31/25.F. On 01/08/26 at 1:13 pm, during an interview with the ADM, she confirmed NAIT #2 has not yet received her certification and continued to work shifts during that time. She stated her expectation is for all nurse aids to become certified within four months.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, the facility failed to post nurse staffing data on a daily basis at the beginning of the shift that included the following: 1. Facility name. 2. The current date. 3. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: 1. Registered nurses. 2. Licensed practical nurses. 3. Certified nurse aides. 4. Resident census. This deficient practice has the potential to affect all 109 residents as identified by the census provided by the Administrator on 01/04/2026 and could likely result in residents and visitors not having the staffing information readily available. The findings are:A. On 01/04/2026 at 11:30 AM, during observation of the main entrance, the nurse staffing data was dated 01/02/2026 and was not posted for the current day. B. On 01/04/2026 at 11:35 am, during an interview with the Interim Director of Nursing (IDON) she confirmed the nursing staff data should be posted daily and was not.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs by ensuring medications have an adequate indication of use and ensuring indication of use is based off the residents' current diagnosis for 1 (R #63) of 2 (R #21 and #63) residents reviewed for unnecessary medications. This deficient practice could likely lead to adverse drug effects and poor patient outcomes. The findings are: A. Record review of R #63's admission record revealed R #63 was admitted on [DATE] with the following diagnoses:1. Lymphedema (chronic swelling),2. Chronic pain,3. Bi-polar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),4. Adjustment disorder (a strong emotional or behavioral reaction to a specific, identifiable stressor),5. Hypothyroidism (the thyroid is not making enough thyroid hormone).B. Record review of R #63's physician record revealed an order for Carbidopa-Levodopa (a medication used primarily to treat Parkinson's disease) oral (by mouth) tablet 25-100 milligrams (MG). Give 1 tablet by mouth at bedtime for Parkinson's disease. Start date 12/18/25. C. Record review of R #63's Medication Administration Record (MAR) dated January 2026 revealed R #63 received Carbidopa-Levodopa daily from 1/01/26-01/05/26: D. On 01/08/26 at 11:47 am, during an interview with the Interim Director of Nursing (IDON), she confirmed R #63 does not have a diagnosis of Parkinson disease. She confirmed the indication of the medication does not reflect the R #63's current diagnoses

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews and interviews, the facility failed to ensure a medication error rate of less than 5% as ordered to 3 (R #s 5, 20, and 100) of 6 (R #s 1, 5, 20, 33, 86, and 100) residents reviewed. During the survey period, the survey team observed 27 opportunities for error and identified 3 errors, resulting in a medication error rate of 11.11%. Failure to administer medications as ordered could result in residents not receiving the full benefit of the medication regime. The findings are:R #5A. Record review of R #5's physician's order dated 10/15/25 revealed an order of wound care to the sacrum (area of the body at the base of the spine), cleanse with wound cleanser, pat dry, apply zinc (topical medication used to treat and prevent skin irritation), an apply optifoam (a specialty dressing for wound healing).B. On 01/08/26 at 9:16 am, observation of a scheduled wound care to R #5, LPN (licensed practical nurse) #1 used normal saline instead of wound cleanser.C. On 01/08/26 at 9:35 am, during an interview with LPN #1, he stated that he could not find any wound cleanser and decided to use normal saline instead. LPN #1 confirmed that he did not follow the order.R #20D. Record review of R #20's physician's order dated 08/05/25 revealed an order of Reglan (prescription medication used primarily to treat gastroparesis [slow stomach emptying]) tablet 5 mg (milligrams), give 1 tablet via PEG-tube (percutaneous endoscopic gastrostomy tube, is a flexible feeding tube inserted through the abdominal well directly into the stomach) four times a day for gastric motility (refers to the coordinated contraction and relaxations of the stomach muscles).E. On 01/04/26 at 11:20 am, during observation of medication administration, the State Agency (SA) observed three medication cups (each with prescribed medications in them, each with resident room numbers written on them) pre-poured by The Certified Medication Aide (CMA) #1. One of the medication cups has a green oblong pill stamped with Reglan 5 was accidentally touched by the SA. The CMA #1 witnessed the SA touch the medication. CMA #1 continued to crush the medication and administered the contaminated pill to R #20 via PEG-tube.R #100F. Record review of R #100's physician's order dated 11/04/25 revealed an order of rybelsus (prescription medication used to treat type 2 diabetes [DM2; a disease in which the body cannot make or properly use insulin]) tablet 7 mg given by mouth one time a day, take 30 mins before food/drink.G. On 01/06/26 at 8:41 am, during medication administration, LPN #2 was observed to administer the medication while R #100 is finishing his breakfast. H. On 01/06/26 at 8:43 am, during an interview with LPN #2, she stated that she did know it should be given 30 minutes before any food or drink.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and interviews, the facility failed to properly store medications and medical supplies located in the facility medication carts and medication storage room when the staff failed to ensure:-Medication carts are free of any lose pills.-Medication carts are not left unlocked and unattended. -Expired medication and supplies are properly discarded.-Medications of discharged residents are taken out of the medication cart.-Medication fridge temperature is being monitored routinely.These deficient practices have the potential to affect all 109 residents as identified by the census provided by the Administrator on [DATE]. If the facility does not ensure safe storage practices, then residents are at risk for adverse effects due to improper storage and not receiving the full benefits of medications. The findings are:A. On [DATE] at 8:20 am, observation of the 200-hall medication cart, revealed the following: a yellow capsule stamped with PRA 1, a white square tablet stamped with CC, a white round tablet stamped with G10, and a pink round tablet stamped with H1 were found in the second drawer.B. On [DATE] at 8:22 am, during an interview with Certified Medication Aide (CMA) #1, she confirmed those medications found in the second drawer should be disposed of according to facility policy. CMA #1 stated that medication carts should be free of any lose pills as part of the facility infection control.C. On [DATE] at 6:12 pm, during an observation of the 200-hall medication cart, a white round pill stamped with GC216 was found on top of sharps container.D. On [DATE] at 6:14 pm, during an interview with Licensed Practical Nurse (LPN) #4, she confirmed that a white round pill stamped with GC216 was found on top of the sharp's container. LPN #4 stated, per facility policy, medications are disposed by placing them inside a drug buster (a drug disposal system designed to safely and effectively dispose of non-hazardous medications).E. On [DATE] at 8:39 am, during an observation of hall 100, a treatment cart (containing medical supplies and insulin pens) parked outside room [ROOM NUMBER] was left unlocked and unattended.F. On [DATE] at 8:41 am, during an interview with CMA #2, she confirmed the medication cart was left unlocked and unattended. CMA #2 stated that medication carts are to be locked when not in use and it did not happen.G. On [DATE] at 8:44 am, during an observation of the 200 halls, a medication cart was left unlocked and unattended outside room [ROOM NUMBER].H. On [DATE] at 8:46 am, during an interview with Registered Nurse (RN) #1, she confirmed that the cart was left unlocked and unattended. I. On [DATE] at 11:05 am, during an observation of the 100-hall treatment cart revealed the following:1. A ceftriaxone (an antibiotic) 1 gram vial for R #122 was found (R #122 left the facility last month).2. An aquacell dressing (a brand of wound care dressing) with an expiration date of [DATE] was found.3. An unwrapped syringe found in the first drawer.J. Record review of R #122's face sheet revealed a discharge date of [DATE].K. On [DATE] at 11:07 am, during an interview with LPN #5, he confirmed the following:1. R #122 was discharged last month. The antibiotic should have been returned pharmacy or disposed according to facility policy, and it did not happen.2. The aquacell dressing is expired. All expired medication supplies should have been removed, and it did not happen.3. The syringe is unwrapped and appears unused. Unused medical supplies such as a syringe should discarded as soon as they are opened to prevent potential contamination and it did not happen.L. On [DATE] at 11:11am, during an observation of the locked medication room, revealed the following:1. The medication fridge door is open with and internal temperature reading of 52.4 degrees Celsius.2. A culture swab kit (a diagnostic tool used to collect sample and send it to the laboratory) with an expiration date of [DATE].3. A 22-gauge (needle size) syringe with an expiration date of [DATE] was found.M. On [DATE] at 11:14 am, (continued on next page)

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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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	during an interview with LPN #5, he confirmed the following:1. The medication fridge was left open with an internal temperature reading of 52.4 degrees Celsius.2. The culture swab and syringe are expired.

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	325064	A. Building B. Wing	01/08/2026

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure transportation was provided for a scheduled oncology (the study and treatment of tumors) appointment for 1 (R #94) of 1 (R #94) resident reviewed. This failure resulted in the resident missing a prescribed chemotherapy treatment, potentially impacting the resident's health outcomes.The findings are:A. Record review of R #94's face sheet revealed he was admitted to the facility on [DATE] with the following diagnoses (including but not limited to):1. Malignant neoplasm of colon, unspecified (also known as colon cancer, cancer that forms in the tissues of the colon).2. Secondary malignant to neoplasm of liver and intrahepatic bile duct (cancers that arise in the liver or the bile ducts within the liver).3. Encounter for antineoplastic chemotherapy (resident is receiving chemotherapy treatment).B. Record review of the oncology visit dated 12/09/25 revealed R #94 has upcoming oncology treatment schedules dated 12/16/25, 12/30/25, 01/06/26, and 01/13/26.C. Record review of R #94's care plan dated 05/08/25 revealed R #94 is at risk for adverse reactions (undesirable and harmful response) to cancer (colorectal [colon and the rectum] cancer with metastasize [spread to other] to liver), currently receiving chemotherapy. D. On 01/06/26 at 2:50 pm, during an interview with R #94, he stated that he missed his 12/30/25 oncology chemotherapy treatment due to the facility not providing transportation going to his appointment that day. R #94 further stated, the facility gets a copy of all of his appointments and he has been going to chemotherapy treatment on a weekly basis since he's at the facility.E. On 01/07/26 at 9:15 am, during an interview with the oncology clinic registered nurse navigator, she confirmed R #94 missed his 12/30/25 oncology treatment appointment. She stated R #94 did not have a transport scheduled to take him to the oncology clinic when she called the facility.F. On 01/08/26 at 9:42 am, during an interview with the Unit Clerk (UC), she stated that she schedules transport for all the residents going to appointments and UC was not aware of the 12/30/25 oncology treatment appointment. UC confirmed R #94 missed his 12/30/25 oncology appointment due to the inability to provide transport. UC also stated she schedules transport to appointments as she receives the information from the nurses and it did not happen.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident received dental services for 2 (R #34 and R #56) of 3 (R #3, R #34, and R #56) residents reviewed for dental care. This deficient practice could likely result in residents experiencing tooth decay, tooth pain, and difficulty chewing. The findings are: R #34A. Record review of R #34's admission Record revealed R #34 was admitted to the facility on [DATE] with the following diagnoses:1. Personal history of transient ischemic attack (TIA; when blood flow to part of the brain stops for a brief period),2. Congestive heart failure (CHF; impaired heart function),3. Diabetes mellitus (a condition that results from insufficient production of insulin, causing high blood sugar),4. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),5. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).B. On 01/04/26 at 2:16 pm, an observation and interview with R #34 in her room revealed the following:1. R #34 stated that she had not been to a dentist since her admission at the facility.2. R #34 has several missing teeth throughout her mouth.3. R #34 said she has told several staff members that the broken tooth bothers her but still hasn't had a dental appointment.C. Record review of R #34's care plan initiated on 08/29/22 revealed R #34 exhibits or is at risk for oral health or dental care problems as evidenced by multiple missing teeth.D. Record review of R #34's electronic health record (EHR) revealed a dental appointment dated 08/16/23, no further documentation of dental evaluations.E. On 01/08/26 at 9:53 am during an interview with the Scheduler (SCH) she confirmed R #34 has not had a dental appointment since being admitted to the facility. The Scheduler confirmed that due to R #34's dental issues, she should have been evaluated by a dentist.R #56F. Record review of R #56's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Type 2 Diabetes Mellitus (DM2; (a condition that results from insufficient production of insulin, causing high blood sugar),2. Acute congestive heart failure (CHF; impaired heart function),3. Non-ST-elevation myocardial infarction (NSTEMI; a type of heart attack)G. On 01/04/26 at 1:25 pm, an interview and observation with R #56 in her room revealed the following:1. R #56 stated that she needs to go to the dentist.2. R #56 has a missing tooth in the front of her mouth.H. Record review of R #56's EHR revealed no documentation of R #56 being evaluated by a dentist since her admission.I. On 01/08/26 at 9:53 am, during an interview with the Scheduler (SCH), she confirmed R #34 and R #56 have not been seen by a dentist since being admitted to the facility. The SCH stated that she expects all residents to have an annual appointment with a dentist. The SCH stated that she tries to keep up with all residents to ensure they are seen by a dentist annually and must've missed scheduling for R #34 and R #56.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review and interview, the facility failed to ensure the nutritional needs and preferences were met for all 109 residents list on the resident census list provided on 01/04/26 by the facility Administrator by not following the menu. This deficient practice could prevent residents from eating well, not meeting their nutritional needs and lead to weight loss. The findings are: A. On 01/04/26 at 11:40 am during an observation of lunch in the main dining room, ice cream was served for dessert.B. Record review of the menu for lunch dated 01/04/26 revealed, pizza, broccoli, strawberry streusel.C. On 01/04/26 12:16 pm during an interview with the Dietary Manager, she stated she had an employee call in for a shift and she had to cover the shift. She also stated it was late when she got to facility and she did not have time to make the strawberry streusel.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure food was prepared and served under sanitary conditions when staff failed to:1. Properly label drink items while on carts in 400 hallway, 2. Properly store milk on ice on cart in 400 hallway,3. Properly label and store foods in the kitchen.These deficient practices are likely to affect all 109 residents listed on the resident census list provided by the Administrator on 1/04/26 and are likely to lead to foodborne illnesses in residents if safe food handling practices are not adhered to and stored properly. The findings are: A. On 01/04/26 at 11:40 am, observation of the Dietary Department, revealed the following: 1. Half of a five-pound boneless ham was in the walk-in-refrigerator and was not dated.2. One five-pound bag of diced potatoes was open to air and not sealed properly in the walk-in refrigerator.3. One ten-pound box of frozen beef patties was open to air and not sealed properly in the freezer.4. One 5-pound bag of grapes was open to air not sealed properly and was not dated.5. One zip lock bag with what appeared to be 6 halves of ham & cheese sandwiches in the refrigerator and were not dated.B. On 01/04/26 at 11:43 am during an interview with Dietary Manager, he confirmed all items above and stated he expected all items to be sealed properly and dated.C. On 01/05/26 at 8:32 am, an observation of the kitchen cart in hallway 400 revealed what appeared to be coffee, milk, and juice and did not have a label indicating the contents or date it was prepared.D. On 01/05/26 at 8:34 am, during an interview with Registered Nurse (RN) #2, she confirmed the milk, coffee and juice on the 400-hallway cart were not labeled and dated. She stated all beverages should be properly labeled.E. On 01/07/26 at 8:20 am, an observation of the kitchen cart in hallway 400 revealed what appeared to be milk not sitting on ice.F. On 01/07/26 at 8:34 am, during an interview with Certified Nursing Assistant (CNA) #1, she confirmed the milk on the cart down the 400 hallway was not sitting on ice. She confirmed all drinks should be placed on ice to stay cold.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received rehab therapy (intended to restore the body to their highest degree of performance) services within a reasonable timeframe after the doctor ordered it for 1 (R #5) of 1 (R #5) resident reviewed for rehab services. This deficient practice is likely to result in a decrease in residents' functional mobility. The findings are:A. On 01/05/26 at 6:30 pm during an interview with R #5, she stated, I have not been in therapy and no one has seen me about it. I would like to go to therapy. B. Record review of R#5 face sheet revealed R #5 was admitted on [DATE] with the following diagnosis:1. Non-active primary progressive multiple sclerosis (a gradual worsening of neurological symptoms without the occurrence of relapses or remissions),2. Contracture of muscles (a permanent shortening or tightening of the muscle) in the right lower leg, left leg, and right upper arm,3. Secondary progressive multiple sclerosis unspecified (a stage of multiple sclerosis). C. Record review of R #5's physical therapy evaluation dated 06/09/25 revealed R #5 has on order for Physical Therapy 5 x (times)/week for 4 weeks from 06/09/25 to 07/07/25.D. Record review of R #5's physical therapy treatment encounter note dated 12/23/25 revealed R #5 has only had one Physical Therapy session. E. Record review of R #5's Physician's Orders dated 12/23/25 revealed the following:1. An active order for Physical Therapy three times per week for 30 days for skilled PT services including range of motion (ROM; the extent or limit to which a part of the body can be moved around a joint or a fixed point), safe transfers, and bed mobility. 2. An order for Restorative Nursing Program (RNP) 3 times per week for passive range of motion (the movement of a joint or muscle by an external force like a therapist or machine) to BLE (bilateral lower extremities) and AROM (active range of motion; the movement of a joint or muscle by the person) to BUE (bilateral upper extremities) to improve quality of life. F. On 01/08/25 at 12:57 pm, during an interview, the Activities Director (AD), stated she oversaw the Restorative Nursing Program and had not received an order from the DOT to initiate RNP for R #5. She confirmed that R#5 had an active RNP order and was not receiving any restorative services.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, record review and interview, the facility's Administrator (ADM), Infection Prevention Coordinator (IPC) and Interim Director of Nursing (IDON) failed to administer the facility when they knew/should have known and prevented the following deficient practices which occurred in the facility: 1. Not ensuring staff were trained and/or competent before providing care to residents,2. Not ensuring appropriate infection control practices for residents with contact precautions,3. Failure to know specific orders are required for oxygen use. These deficient practices are likely to affect all 102 residents residing in the facility according to the daily census provided by the Admissions Coordinator (AC) on 12/07/25 and could lead to residents not maintaining their highest practicable physical, mental, and social well-being. The findings are: Staffing A. Record review of the Requested Documents form (form surveyors submit to a facility to request certain documents) dated 01/08/26 revealed the Administrator (ADM) wrote the following:1. Nurse Aide in Training (NAIT) #1 was certified as a Certified Nurse Aide (CNA) on 10/09/24.2. NAIT #2 was certified as a Certified Nurse Aide (CNA) on 06/09/25.3. NAIT #3 was certified as a Certified Nurse Aide (CNA) on 04/23/25.B. On 01/08/26 at 1:13 pm during an interview with the ADM, she stated that she was unaware that surveyors needed to see the staff's actual certification status and would gather them to submit to the survey team.C. Record review of NAIT #1's personnel file revealed a start date of 10/09/24, no evidence of NAIT #1 becoming as a certified nurse aide was located in the file.D. Record review of NAIT #2's personnel file revealed a start date of 06/09/25, no evidence of NAIT #2 becoming a certified nurse aide was located in the file.E. Record review of NAIT #3's personnel file revealed the following:1. A start date of 04/23/25.2. No evidence of NAIT #3 becoming a certified nurse aide was located in the file.3. The Non-certified Nursing Aide Job Description was signed and dated by NAIT #3 on 04/16/25. No job description for transportation staff was located in the file.F. On 01/08/26 at 1:47 pm during an interview with the ADM, she confirmed that NAIT #1 and NAIT #2 are scheduled to complete the testing and become certified on 01/31/26. The ADM stated that NAIT #1 and NAIT #2 have continued to work in a nurse aide capacity even though they are not certified. The ADM confirmed that NAIT #3 is not a certified nurse aide and stated that NAIT #3 is not being utilized in a nurse aide role because she is being used as a transport staff. Infection Control PracticesG. Record review of the facility's Infection control policies and procedures for Transmission Based Precautions dated 05/01/25 indicated to refer to Centers for Disease Control and Prevention (CDC).H. Record review of CDC guidelines from CDC website Enhanced Barrier Precautions (EBP) in Nursing Homes. Centers for Disease Control. https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html Implementation of Contact precaution or Enhanced Barrier Precautions, the CDC recommends: That clear signs be displayed outside the door of the room where precautions are required. The sign should indicate the type of precaution and PPE to be used during high-contact resident care activities.I. On 01/04/26 at 11:43 am, during a random observation of the 100-hall, revealed R #21 had a sign for Modified Protection Environment at the doorway and personal protective equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) hanging from the door. The Modified Protection Environment sign listed the following precautions:1. No live plants2. No dried or fresh flowers3. No Animal Visits4. Avoid visitation from ill persons/caregivers5. Strict hand hygiene must be preformed.The Modified Protection Environment sign did not indicate the type of precautions and PPE to be used during care.J. On 01/05/26 at 8:11 am, during an interview with the infection prevention coordinator, she confirmed. The sign posted at the doorway of R #21's room for Modified Protection Environment did not indicate the type of precautions and PPE to be (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	used during care. R #21 should have an additional sign for contact plus droplet precautions but was not visibly posted. The IPC explained that the resident has additional environment precautions due to being on chemo (medication to treat cancer).K. On 01/05/26 at 8:13 am during an observation of the 100-hall, R #21 had a contact plus droplet precaution sign posted at the doorway of R#21's room with the following precautions:1. Staff must clean hands before enter and leaving room,2. Staff must wear gown and gloves,3. Staff must wear procedure mask and eye protectionL. On 01/07/26 at 8:17am, during a random observation of the therapy room revealed R #21 was in the therapy room. The speech language pathologist (SLP) #1 was assisting R #21 with hygiene and drink, therefore R #21 was not wearing a mask. There were three other staff in the therapy room. No staff were wearing gowns or face shields. There were three other residents in the therapy room not wearing any type of PPE.M. On 01/07/26 at 8:32am during an interview with the IPC, she stated that R #21 is only required to wear a mask as tolerated. The IPC stated that it would be her recommendation to have R #21 perform therapy in his room however his family has asked that he have therapy outside of his room. The IPC also stated that R #21 is not at risk because the increase precaution would depend on his blood cell count to determine the need for reverse isolation (a medical practice designed to protect patients with weakened immune systems from infections by minimizing their exposure to pathogens in the environment). The IPC then stated that although R #21 is on contact plus droplet precautions the purpose of the precaution was because R #21's family requested the precautions. She also state that the facility cannot force residents to stay in their rooms or require residents to wear a mask if they choose not to. The IPC confirmed that R #21 is non ambulatory and requires assistance with all ADL's. She also confirmed R #21 has limited communication requiring yes and no responses.N. On 01/07/26 at 8:51 am during an interview with R #21's representative, she stated R #21 is on neutropenic precautions (infection-prevention measures for individuals with a low white blood cell count) per his oncologist (a doctor who specializes in diagnosing and treating cancer). She stated the facility should have received an order from the facility he was at prior to admission. She confirmed R #21 is currently receiving chemo every other week and the family has requested that R #21 receive therapy in his room due to the current COVID exposure in the facility. She stated the family would prefer that staff wear full PPE when caring for R #21 however was told by the facility that the only need for R #21 to have contact precautions is due to R #21 wound care.O. Record review of the facility's Modified Protection Environment policy revealed the facility will obtain orders for the following:1. Whether the resident should take a bath or shower.2. The amount of time a resident can be outside of their room.3. Requirements for the resident to wear a surgical mask.4. Any other modification or changes needed for the resident.P. On 01/08/26 at 10:22 am, during an interview with the IPC she confirmed that her expectation is that facility polices be followed for all residents. She confirmed the facility is currently on COVID precautions. She confirmed R #21 did not have orders for the following:1. Whether R #21 should take a bath or shower.2. The amount of time a R #21 can be outside of his room.3. Requirements for R #21 to wear a surgical mask.4. The need for Contact plus droplet precautions.The IPC stated the facility does not have neutropenic precautions however the Modified Environment is an alternative for residents who would require neutropenic precautions. She stated the facility provider would give recommendations and orders for residents who need additional precautions based off a resident's increased risk of infection from decreased blood cells from lab work. The IPC stated that risk of infections for residents receiving chemo is not part of her infection program and she could not confirm if R #21 has had a low reading in his blood work. She confirmed the provider was not consulted regarding R #21 and need for additional precautions. Failure to know specific orders are required for oxygen (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	use:Q. Record review of R #20's current medical orders revealed an order dated 03/21/23 for R #20 to use oxygen at one to six liters per minute via (by way of) nasal cannula continuously.R. Record review of R #35's current medical orders revealed an order dated 03/29/25 for R #35 to utilize three to four liters of oxygen per minute via nasal cannula.S. Record review of R #41's physician record revealed there were no orders for use of oxygen or oxygen device care.T. On 01/04/26 at 11:58 am, an observation and interview of R #71 in his room revealed the following:1. A continuous positive airway pressure (CPAP) machine connected to a medical stand located next to R#71's bed.2. R #71 stated that he was sent to the facility with the CPAP and that he uses the CPAP every night.U. Record review of R #71's discharge documentation from a hospital dated 02/03/25 revealed the following:1. R #71's primary diagnosis was acute and chronic respiratory failure with hypoxia (insufficient oxygen in the blood over a long period of time). 2. The use of a CPAP was ordered.V. Record review of R #109's current medical orders revealed the following:1. An order dated 12/31/25, for R #109 to wear oxygen at one to five liters via nasal cannula continuously.2. An order dated 12/31/25, for R #109 to have oxygen on at one to five liters via nasal cannula as needed.W. On 01/08/26 at 11:45 am an interview with the Interim Director of Nursing (IDON) revealed the following:1. The IDON confirmed that the order for R #20's and R #35's oxygen use do not specify the amount of oxygen (liters and flow rate) required.2. The IDON confirmed R #41 does utilize oxygen, should have an order for the use of oxygen and does not.3. The IDON confirmed R #71 does utilize a CPAP, should have an order for the use of the CPAP and does not.4. The IDON confirmed that the order for R #109's oxygen use does not specify the amount of oxygen needed and whether he needs continuous or PRN oxygen.5. The IDON stated that orders do not have to specify the amount of oxygen a person needs because it is up to the nurse and the nurse's judgement to keep a resident's oxygen saturation level above 90.

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 01/08/2026
NAME OF PROVIDER OR SUPPLIER: Skies Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 9150 McMahon Boulevard NW Albuquerque, NM 87114	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, and interviews, the facility failed to protect residents' personal health information (PHI) by leaving a document containing multiple residents' information (such as names, diagnoses, treatment plans, or room numbers) in a hallway. This deficient practice has the potential to affect residents residing on the 300 and 200 hall and can lead to unauthorized access to sensitive information, putting residents' privacy at risk.The findings are:A. On 01/05/26 at 2:11 pm, during an observation of the medication cart outside room [ROOM NUMBER], a white piece of paper with residents full name, room number and code status was left unattended and exposed to public view.B. On 01/05/26 at 2:15 pm, during an interview with Licensed Practical Nurse (LPN) #3, she confirmed that the white paper contained resident's identifier and should be kept hidden from public view and it did not happen.C. On 01/07/26 at 8:46 am, during an observation of the medication cart outside room [ROOM NUMBER], the computer containing resident's electronic medical record was left unlocked and exposed to public view unattended.D. On 01/07/26 at 9:02 am, during an interview with Registered Nurse (RN) #1, she confirmed that the electronic health record was left exposed to public view unattended.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to implement and follow an ongoing infection prevention and control program (a program that is used to prevent, recognize, and control the onset and spread of infections) by 1. Not ensuring transmission-based precautions (actions implemented based upon the means of transmission to prevent or control infection) signs are posted outside of rooms with Personal Protective equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection).2. Not ensuring staff follow the appropriate precautions posted.These failed practices have the potential to affect all 109 residents living in the facility as identified by the census provided by the Administrator 01/04/26. These deficiencies place residents at risk of contracting infections, hospitalization, and death. The findings are:Transmission Based Precautions:A. Record review of the facility's Infection control policies and procedures for Transmission Based Precautions dated 05/01/25 indicated to refer to Centers for Disease Control and Prevention (CDC).B. Record review of CDC guidelines from CDC website Enhanced Barrier Precautions (EBP) in Nursing Homes. Centers for Disease Control. https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html Implementation of Contact precaution or Enhanced Barrier Precautions, the CDC recommends:1. That clear signs be displayed outside the door of the room where precautions are required. The sign should indicate the type of precaution and PPE to be used during high-contact resident care activities.2. PPE available immediately outside of the resident room.3. Ensure access to alcohol-based hand rub in every resident room4. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room.C. On 01/04/26 at 11:43 am, during a random observation of the 100-hall, revealed the following:1. room [ROOM NUMBER] had a sign for Modified Protection Environment at the doorway and PPE hanging from the door. The Modified Protection Environment sign did not indicate the type of precautions and PPE to be used during care.2. rooms [ROOM NUMBERS] had signs for Special Contact and Droplet Precautions posted at the doorways and PPE hanging from the doors.3. Rooms 104, 106, 110 and 114 had Enhanced Barrier Precautions posted at the doorways and PPE hanging from the doors.D. On 01/04/26 at 12:05 pm, an observation of room [ROOM NUMBER] revealed the resident had an indwelling catheter (a thin, flexible tube inserted into the body used to drain urine from the bladder). E. On 01/04/26 at 1:27 pm during an interview with Certified Nurse Aide (CNA) #5, she confirmed the resident in room [ROOM NUMBER] had an indwelling catheter and did not have a sign for transmission-based precautions or PPE available. F. On 01/05/26 at 8:09 am during an observation of the 100 hall, revealed the infection control coordinator removing a contact plus droplet precaution sign from the PPE caddy (a device hanging on the door of the residents' room to hold PPE for easy accessibility). G. On 01/05/26 at 8:11 am, during an interview with the infection prevention coordinator, she confirmed the following:1. Residents with an indwelling catheter should be on Enhanced Barrier Precautions and have PPE available.2.The sign posted at room [ROOM NUMBER] Modified Protection Environment sign did not indicate the type of precautions and PPE to be used during care. room [ROOM NUMBER] should have an additional sign for contact plus droplet precautions but was not visibly posted. Following PrecautionsH. On 01/04/26 at 12:11 pm during a random observation of the 100 hall, CNA #3 entered room [ROOM NUMBER] without PPE.I. On 01/04/26 at 12:13 pm during an interview with CNA #3, he confirmed room [ROOM NUMBER] is on special contact and droplet precautions. CNA #3 confirmed he should be wearing a gown, N95 respirator (personal protective device that forms a tight seal around the nose and mouth, filtering at least 95% of airborne particles), eye protection or face shield when entering the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room and he did not.J. On 01/05/26 at 8:53 am, during a random observation of the 100-hall revealed the following:1 The Occupational Therapist (OT) #1 exited room [ROOM NUMBER] with complete PPE to include gown and mask. 2. OT #1 walked down the hall and then returned to enter room [ROOM NUMBER] still wearing the PPE. K. On 01/05/26 at 8:56 am, during an interview with OT #1, he confirmed that he should not have exited the room before donning (removing) his PPE and should put new PPE on each time he enters the room.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to ensure call lights in the residents' rooms were within reach of the residents while in the room for 2 (R #22 and R #56) of 4 (R #2, R #8, R #22, and R #56) residents reviewed for call lights. This deficient practice could likely result in residents being unable to notify staff when they are in need of assistance. The findings are:R #22 A. On 01/05/25 at 10:34 am during an observation of R #22's room revealed R #22 was asleep in her recliner. The call light lay on top of the bed where she could not reach it.B. On 01/05/25 at 10:36 am during an interview with Hospice Nurse (HN) #1, she confirmed the call light was not within R #22's reach and the call light should have been. R #56C. On 01/05/25 at 8:58 am during an observation of R #56's room, revealed R #56 was asleep in his recliner. The call light lay on top of the bed where he could not reach it.D. On 01/05/25 at 9:05 am during an interview with Certified Nurse Assistant (CNA) #2, she confirmed the call light was not within R #56's reach and the call light should have been.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) and Nurse Aides in Trainings (NAIT) received the required in-service training of 12 hours per year for 2 (CNA #4 and NAIT #1) of 5 (CNA #2, CNA #4, NAIT #1, NAIT #2, NAIT #3) CNA's reviewed for training. This deficient practice is likely to result in the CNAs not receiving the necessary training to meet the care needs of the residents.The findings are:CNA #4A. Record review of CNA #4's personnel file revealed CNA #4 was hired on 04/17/24.B. Record review of CNA #4's in-service training transcript report revealed CNA #4 completed nine and a half hours of in-service training from 01/27/25 to 09/23/25.C. On 01/08/26 at 12:00 pm during an interview with the Director of Nursing (DON), she stated that she expects all CNAs to complete the required amount of training each year and confirmed that CNA #4 has not. NAIT #1D. Record review of the facility's staff list provided by the administrator on 01/08/25, listed NAIT #1's as a certified nurse aide.E. Record review of NAIT #1's personnel file revealed #NAIT #1 was hired on 10/09/24.F. Record review of NAIT #1's in-service training transcript report revealed NAIT #1 completed zero hours of in-service training from hire date of 10/09/24 to 12/31/25.G. Record review of NAIT #1's work schedule from 01/01/25 to 12/31/25, revealed she worked a total of 151 days.H. On 01/08/26 at 12:01 pm during an interview with the Administrator (ADM), she stated that she expects all Nurse Aid in training (NAIT) to complete the required amount of training each year and confirmed that NAIT #1 has not. ADM also confirmed that they could not find any education files for NAIT #1.