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	08/24/2021

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33768 Based on record review and interview, the facility failed to ensure that a resident received care needed to prevent the development and worsening of a pressure ulcer for 1 (R #15) of 5 (R #15-19) residents reviewed for pressure ulcers. This deficient practice likely resulted in R #15 developing a unstageable pressure wound (full thickness skin and tissue loss in which extent of tissue damage within the ulcer cannot be confirmed) before any treatment orders were implemented. The finding are: A. Record review of the History and Physical (Hand P) for R #15 dated 07/09/21 revealed the following diagnoses: PMHx of hypothyroidism, DM II, and chronic anticoagulation use from unclear cardiac hx (CHF or AFIB) who was admitted to [Name of Nursing Home] on 7/5/21 after having been admitted to [Name of Local Hospital] on 6/28/21 for Altered mental status (AMS) and increased oxygen requirements (3 to 5L NC) where they were found to have acute metabolic encephalopathy, moderate pleural effusion, acute hypoxic respiratory failure, CAP vs aspiration PNA, UTI, and RLE [NAME] ankle fracture. She was admitted to skilled nursing at [Name of Nursing Home] for PT/OT/ST. B. Record review of R#15 Discharge summary dated 07/04/21 from [Local Hospital], identified no skin breakdown. C. Record review of R#15 Weekly Bath and Skin report revealed the following: 1. 7/6/21: normal (no abnormal skin changes); not signed by charge nurse 2. 7/8/21: normal (no abnormal skin changes); not signed by charge nurse 3. 7/10/21: normal (no abnormal skin changes); not signed by charge nurse 4. 7/13/21: normal (no abnormal skin changes); redness/rash and bruising; bilateral ankles and right calf; signed by charge nurse. 5. 7/15/21: normal (no abnormal skin changes); not signed by charge nurse 6. 7/15/21: normal (no abnormal skin changes); not signed by charge nurse 7. 7/17/21: normal (no abnormal skin changes); not signed by charge nurse (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	8. 7/20/21: normal (no abnormal skin changes); not signed by charge nurse. Completed by CNA (Certified Nurse Aide) #3 9. 7/22/21: normal (no abnormal skin changes); not signed by charge nurse. Completed by CNA (Certified Nurse Aide) #3 10. 7/24/21: completed by CNA, resident refused; not signed by charge nurse 11. 7/27/21: normal (no abnormal skin changes); signed by charge nurse. Completed by CNA (Certified Nurse Aide) #3 12. 7/29/21: redness/rash to buttocks; not signed by charge nurse. Completed by CNA (Certified Nurse Aide) #3 13. 7/31/21: open areas to buttocks; not signed by charge nurse (documented that nurse was notified on report). Completed by CNA (Certified Nurse Aide) #3 14. 8/3/21: open area identified on buttocks; not signed by charge nurse. Completed by CNA (Certified Nurse Aide) #3 D. Record review of TAR (Treatment Administration Records) dated JULY 2021 revealed No treatments for wounds. E. Record review of R#15's TAR dated AUGUST 2021 revealed: 1. 8/1/21 20:00 with note to document on the 24 hours shift report if resident refuses and orders for offloading/turning orders every 2 hours; 2. 8/2/21 for Offloading/turning orders 3. 8/3/21 Daily wound care orders to sacrum ordered but not done; 4. 8/3/21 PRN (as needed) order for Santyl ointment (to sacrum; 5. 8/4/21 0600 Santyl Ointment to sacrum every day shift started at 6am on 8/4 x1treatment completed; Wound care orders to sacrum daily ordered at 0600 8/4/21 but not done. F. Record review of R#15 Care Plan identified that R#15 was at risk for skin breakdown related to limited mobility dated 7/6/21: Observe for signs/symptoms of skin breakdown and evaluate for any localized skin problems. 1. Revision of Care Plan dated 8/1/21 indicated wounds worsening related to resident refusal to turn and get out of bed; 2. Revision of Care Plan dated 8/2/21 added Offloading/turning orders 3. Revision of Care Plan dated 8/4/21 for sacrum wound orders and wound treatment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	G. Record review of R#15 Skin Check dated 8/1/21 identified a scab to inner left ankle; flaking of feet/toes; right leg ortho boot; discoloration to buttocks; rash under pannus on left side H. Record review of R#15 Skin Integrity dated 8/1/21, completed by the Wound Care Nurse/Registered Nurse (RN) #1, identified unstageable necrotic tissue to the sacrum; 15x15cm; light serous drainage; inflamed/indurated; no odor noted; note from nurse that resident vehemently refused offloading to either side of buttocks. I. Record review of R#15 Nursing Progress Note revealed the following: 1. 8/2/21: identifies skin being reviewed with no findings; note incomplete 2. 8/3/21: identified no wounds J. On 08/19/21 at 12:27 pm during interview with Certified Occupational Therapist Assistant (COTA) #1, regarding R #15, she stated She was pretty much bed bound. She was non-weight bearing at the time. She had to do a lot of bed mobility. Would need 2 people to move her. I don't believe we ever stood her. I did a lot of bed dressing, bed baths, arm exercises. She eventually had to be a hoyer lift [for transfers]. COTA #1 confirmed that R #15 stopped making progress and therapy was discontinued on 7/20/21.COTA #1 denied R #15 ever refusing to do treatment. K. On 08/23/21 at 10:00 am during interview with the Wound Care Nurse/ RN #1 she confirmed that in July 2021 she quit for a couple weeks and when she returned [08/01/21], she saw R #15's wounds first. RN #2 stated that the wound was 15 by 15 (centimeters) eschar (black tissue). RN #2 confirmed that she entered wound orders that day. L. On 8/23/21 at 11:02 am and 3:11 pm during interview with the Director of Nursing (DON) she reported that R #15s wound started as a skin tear and the Aides were providing barrier cream during brief changes. DON stated that towards the end of July, It went from bad to worse over night. DON confirmed that upon reviewing the records for R #15, she noted that there was inaccurate documentation identifying that R #15 had no wounds. DON confirmed that the CNAs complete the shower sheets and wounds should be identified on those sheets and CNAs are expected to notify the Nurse of any changes. If there are errors on the shower sheets, per the DON, the Nurses are expected to correct those errors and sign the sheets. DON confirmed that while the Wound Care Nurse was gone in July, I was trying to do everything all at once. DON confirmed that before she [DON] left on vacation on [07/29/21], the CNA notified her of the skin tear and I requested to put barrier cream. DON confirmed that R #15 was total dependence for toileting. DON confirmed that she should have been made aware when the wound got worse. DON confirmed that there is no documentation identifying the wound getting worse from a skin tear to becoming unstageable. regarding R #15, the DON stated I can tell you that she never got out of bed. And the most she would be allowed to be turned is changing and when sheets were changed. Yes she was a risk for pressure sores. M. On 08/23/21 at 3:25 pm during interview with CNA #7, she confirmed that she worked a lot with R #15. Regarding her wound, she stated It started a little skin tear. I let the nurse know and the DON. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	I was instructed to do the barrier cream and turn and reposition. [Name of R #15] didn't care to be repositioned, she would call to have her have the pillows removed. It started as skin tear. I noticed that as days went on it was getting worse. I reported to [Name of DON] and nurse that she didn't want to be requisitioned. It was hard to keep her on the side. That's when it progressed more and more. She was using a brief. I went in every 2 hours to change her even if she wasn't wet. 43260

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 33768 Based on record review and interview, the facility failed to ensure that residents received appropriate treatment and services to restore as much bowel function as possible for 1 (R #15) of 1 (R #15) resident reviewed for Gastrointestinal Bleeds (GI), when the facility failed to monitor for changes in bowel or lack of bowel movements. This deficient practice is likely to result in residents being at risk of fecal impaction (hardened stool that is stuck in the rectum or lower colon due to chronic constipation). The findings are: A. Record review of the MDS (Minimum Data Set) for R #15 dated 08/04/21 identified that R #1 was always incontinent of both bowel and bladder. B. Record review of Toilet/Bladder/Bowel (feces) Report for 07/05/21 to 08/04/21 provided an opportunity for CNAs (Certified Nurse Aide) to document toilet/bladder/bowel 4 times each day. From 07/05/21 to 08/04/21, 18 days identified no documentation that R #15 had a bowel movement and no bowel were documented from 07/21/21 to 08/02/21. C. Record review of the Progress Notes for R #15 during 07/21/21 to 08/02/21 did not identify that R #15 had not had a bowel in over 72 hours or any interventions. D. Record review of the Progress Note dated 08/04/21 revealed that R #15 had diarrhea and blood in her stool. E. Record review of Hospital Admission report from Local Hospital dated 08/04/21 revealed that R #15 had a moderate stool ball identified within her rectum. F. Record review of Emergency Department Hospital Admission note dated 08/04/21 revealed Staff at [Name of Nursing Home Company] reports blood in stool x (times) 2 days; Staff was unable to elaborate on color, amount, etc. G. On 08/23/21 at 2:55 pm during interview with the Director of Nursing (DON) when asked if she is tracking residents' bowels, she replied that she is able to pull a list through the dashboard (Electronic medical record in which Certified Nurse Aides (CNAs) enter data) that identifies residents that haven't had a bowel in the last 72 hours. She reported that she gives the list to her Nurse Managers to follow up on the residents identified on the list and they [Nurses] need to find out if there has been a bowel movement or do something about it. The DON confirmed that some nurses don't write a note in the medical record as a follow up on what happened and that she is unaware of the outcome, only that the issue was followed up on. When asked if R #15 was on her triggered list, she reported that she is unable to look back on that list. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. On 08/23/21 at 3:02 pm during interview with Unit Manager (UM) for Hall 200, the UM reported that she is provided a report by the DON on residents have not had a bowel in 72 hours and the list is reviewed in the morning meeting. UM reported that she assigns this task to the the floor nurses for follow up and that the nurses should be documenting their efforts in a Nurse's note. UM stated that she asks the Nurses if the list was followed up on but that she does not verify if the outcome was documented. UM confirmed that a lot of residents trigger due to lack of CNA documentation. UM stated Sometimes the CNAs that were working one day are not here the next day. It really should fall on the Nurses because they are consistent. UM also confirmed that she is not documenting outcome of the list. Regarding R #15, UM confirmed that R #15 did show up on the list for follow up but she is unsure what the outcome was for R #15. I. On 08/23/21 at 3:25 pm during interview with CNA (Certified Nurse Aide) #7 she reported I did notice that she wasn't having bowels. She reported poor eating habits. She was on puree diet she barely ate any food. I would give her a pitcher of water. She didn't drink very much. She'd take a sip while I was in there. J. On 08/24/21 at 9:30 am during interview with the Nurse Practitioner (NP), she stated that unless a resident tells her personally that they have not had a bowel movement, she relies on staff to report issues to her. She also stated that there is not consistent CNAs and that the facility has been short staffed; I assume there is a report procedure [related to bowel frequency and consistency]. NP identified that residents that aren't very mobile are at risk of constipation. NP also identified that indicators of a fecal impaction could be lack of gas, diarrhea, no bowel movements in a few days and dehydration. K. On 08/24/21 at 11:16 am during interview with Registered Nurse #3 regarding documentation of resident bowel movements, he stated We try and chart every day. We rely on our CNAs [to tell us about bowel issues]. I can't say 100 percent if CNAs are charting. RN #3 reported that he follows up on the list provided by management L. On 08/24/21 at 11:45 am during interview with Certified Nurse Aide (CNA) #2 she reported that she worked with R #15 on 08/04/21 [day she was transferred to the hospital] and I knew something was wrong. She was asking to go to the hospital. Regarding documentation of bowels, CNA #2 reported that she documents bowels on a piece of paper [CNA pulled out scrap pieces of paper with handwritten notes]. She also reported that she verbally notifies the Nurse of any concerns.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33768 Based on record review and interview, the facility failed to ensure 1 (R #19) of 1 (R #19) resident reviewed for weight loss maintained acceptable parameter of nutrition when they failed to implement weight loss interventions when R #19 had significant weight loss. The finding are: A. Record review of the Consumer Complaint Form received by the State Agency on 07/26/21 alleged that R #19 had to purchase her own Ensure (nutritional supplement) to meet her nutritional needs during her stay at the facility. B. Record review of the Nutritional assessment dated [DATE] revealed R #19 weighed 105.4 lbs (pounds) on 12/17/21 [date of admission] and that She stated that she has family bring her food for each meal and doesn't eat the food served at the center, but her appetite is good and she eats all the food that her family brings. C. Record review of the Weight Summary revealed the following weights: 1. 12/17/21: 105.4 lbs (pounds) 2. 12/22/20: 102 lbs 3. 12/28/21 97.2 lbs 4. 1/02/21: 98 lbs D. On 08/19/21 at 11:27 am during interview with the RD (Registered Dietician), she confirmed that she runs a report and it identifies residents for weight loss. She confirmed that if a resident was identified as losing weight, they would consider all options, including ordering a nutritional supplement. Regarding R #19, RD confirmed that she was never notified of her weight loss, therefore no interventions were implemented. E. On 8/23/21 at 9:36 am during interview with the Registered Nurse Manager (RNM) #1, she confirmed that weights are taken for residents and those weights are then provided to the RD. The RD then may request re-weighs and decide which resident's should be monitored and weighed weekly. RNM #1 confirmed that R #19 was never on her list for additional monitoring. F. On 08/19/21 at 11:15 am and on 08/23/21 at 11:02 am during interview with the Director of Nursing (DON), she confirmed that R #19 was at the facility for a little over a month, and during her stay R #19's family would bring her food but she was unaware if R #19's family was bringing her Ensure. DON reported that residents are weighed weekly and if there is a weight loss that exceed 5 pounds it triggers discussion. The DON confirmed that nutritional supplements are only provided to residents with an order by the RD or Physician. DON stated that she was unsure why R #19 didn't trigger for weight loss during her stay after a 7 lb weight loss (6 % weight loss).