STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325064	A. Building B. Wing	04/07/2022

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 35632 Based on record review and interview, the facility failed to ensure that staff maintain the right for residents to preserve personal items for 6 (R# 6, 7, 19, 46, 50, and 257) of 6 (R#'s 6, 7,19, 46, 50, 60 and 257) residents reviewed for personal items. This deficient practice is likely to cause the resident to feel that their personal possessions are not treated with respect. The findings are: Record review of the facility's policy titled Personal Property: Patient's, last revised 07/24/18, revealed 2. All possessions or clothing must be marked with patient's name upon admission. 2.1 The Center will provide a laundry marker to the patient and/or responsible party for this purpose. Further review revealed 6. The patient and/or resident representative will be notified of the loss or breakage of personal items, and advised if the loss or breakage will or will not be replaced or repaired at the Center's expense. Findings for R #6 A. On 03/23/22 at 2:33 pm, during an interview with Family Member #1 (FM), she stated that her grandmother is R #6. She stated that she is currently not super happy with the facility. She stated that there are times she has come to visit, and her grandmother has not had pants on just a brief. There are times she has looked in the closet and she has nothing in there even though she buys clothes for her. Her grandmothers clothes are always missing. She stated that she always puts labels with her grandmothers name on them on but she still doesn't get her clothes back. B. Record review of a grievance filed on 03/02/22 indicated that when granddaughter arrived to the facility, she found her grandmother in her underwear in bed. She stated that she had bought her 5 new pair of warm-up pants. When she started to show her grandmother what she bought her, R #6 stated oh good I have no pants on. She stated that she was going to call someone to help her put pants on the granddaughter looked in the drawer where she usually keeps her pants and it was empty and no pants were in the closet. She stated that she also had no socks. The grievance also revealed that she labels all items of her grandmothers clothes with name and number. The grievance also noted that 2 big comforters were missing. One was floral and the other striped white and zig zag. The resolution indicated that: we will return clothes that we have in laundry back to R #6. The pants will be returned when cleaned in laundry. No other documentation was provided for this grievance. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings for R #19 C. On 03/22/22 at 3:30 pm, during interview R #19, she stated that she had missing clothes and a blanket. She told Social Services and the head of laundry, she has been missing clothing since January 2022. She is missing sweat pants, night gown, black velvet pants, sweat shirt. They are all marked with my name on them. She stated that they haven't found them because they are likely in someone else's room. D. Record review of grievance filed on 03/21/22 indicated that R #19 had missing clothes. It is noted clothing that is missing: black velvet pants, night gown, black sweat pants, gray pants and heart sweat shirt. This grievance did not have a resolution for it. Findings for R #50 E. On 03/22/22 at 3:53 pm, during an interview with R #50. she stated that she never gets her laundry back. She didn't even have any pants in her closet even though she has pants, she doesn't know where they are. She wouldn't even have pants on if a staff member didn't go and find some for her. She never gets her laundry back, they put clothes in the wrong closet. Findings for R #46 F. On 03/23/22 at 9:07 am, during an interview with R #46, she stated that she has had 20 to 30 pieces of clothing go missing since she has been here. She has written grievance after grievance and for the most part nothing gets done. It is a total disregard for their rights. She had to move (change rooms) and the staff packed her items and a lot of her items were lost. She stated that she can't recall exactly what went missing now but it was several things. Getting clothing items back has been the worst. Her clothes even have embroidered labels in them with her name. The laundry bleached her new black outfit twice. She just wanted to have a nice outfit to wear to church. She wrote a grievance on that and was told that they have one washer for towels and sheets and those items get bleached and they go into a dedicated washer. Clothing is supposed to go in the other washing machine that does not ever get bleached. She had a green sweater that she loved and waited for months for it to be found. The facility bought her a new sweater but all she wanted was the green one. Clothing is also given away to others who may not have any clothing but then you see your clothing on other residents. Blankets are another item that goes missing and will never be returned. She had lost two. G. Record review of a grievance that was submitted on 02/07/22 indicated that on January 14th, 2022 R #46 did not get her sage green sweater back from the laundry. The grievance indicated that she had put three items into the laundry and received two of them back but not her green sweater. The response at that time was that the laundry aide spoke with R #46 and informed her that she had not seen the sweater and they would continue to look for the sweater and it will be returned if it is found. H. Record review of a grievance that was submitted on 02/15/22 revealed that the sweater is still missing. R #46 indicated that she would send a picture of it to them for identification and stated in the grievance that her name was embroidered on the sweater collar. The grievance also revealed that the sweater was likely in some other residents closet since the laundry aide had not seen it. The response at that time was they continue to search for the sweater if they don't find it they will reimburse her for the sweater. On 03/21/22 R #46 was reimbursed for the sweater. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. On 03/29/22 at 8:45 am during an interview with Housekeeping Manager (HM), she stated that when laundry (sheets) come into the laundry with feces on them, they have a sink in the laundry, and they try there best to clean it off. If they aren't able to get it off, it may get tossed. Personal clothing comes in that way as well and she will try to figure out who's clothing it is and she will write down the name on a piece of paper. No, this isn't always successful with identifying residents clothing. She had received complaints about other residents wearing their clothes. The residents will come up to her and tell her that someone else is in their clothes. The HM stated that it isn't always the laundry that is the problem, sometimes the Certified Nursing Assistants will take clothing from residents and give it to someone else. Yes, she has had complaints from R #19, she is missing black velvet pants, black shirts and is missing a gown. She has been missing them since December 2021. She was also aware that R # 46 was missing a green sweater. Yes, she confirmed that they used to have an issue with personal clothing getting bleached. She stated that she was putting the wrong setting in when she was washing clothes. So the bleach would come out automatically on that setting. She stated that the Center Executive Director has been aware of the issues with the personal clothing issues they have had. J. On 03/29/22 at 9:45 am, during an interview with the Laundry Aide (LA), she stated that missing clothing had been a problem. The LA stated that the family hasn't been labeling the clothes and that she will blame Admissions. If Admissions is not telling family to label clothing than how do they know. K. On 03/29/22 at 10:35 am, during an interview with the Social Services Director (SSD), he stated that he handles the grievances when they come in. He will get the grievance and assign it out to the appropriate department. He had received lots of complaints/grievances about laundry. The problem that he had with the laundry was that he was not sure that they actually ever look for the missing clothing. SSD stated that he will go there (laundry) himself and look. Sometimes the laundry staff will get mad at him or anyone who goes to laundry to look for missing clothes. He stated that laundry tells everyone that there are no names on the clothing, but that isn't true, most of them are clearly marked. Each resident clothes have their name in big letters on it. He stated that 90% of the grievances are about missing clothing. He has told the Center Executive Director but nothing ever gets done or changes. L. On 04/01/22 at 11:44 am, during an interview with CNA #6, she stated that she is aware of the issues with residents wearing other residents clothes. Residents have asked her to get clothes out of their roommates closet. 40795 Findings for R #257: M. On 03/22/22 at 11:45 am, during an interview with the family member of R #257, she stated that R #257 was missing hearing aides, an electric toothbrush, phone charger, and clothes. N. Record review of nursing notes for R #257, dated 10/18/21, revealed Spoke with [name of family member], informed her that electric toothbrush and phone charge will be replaced. Missing hearing aid escalated to CED [Center Executive Director] for further investigation as it has not been located. [Name of family member] verbalized her understanding. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	O. On 04/07/22 at 10:02 am, during an interview with the Social Services Director, when asked if he was familiar with the missing items for R #257, he explained that he was working in a different department during her stay and was not aware of any issues she may have had. When asked if a receipt would be available for any reimbursement of a resident's missing item, he confirmed yes, the receipts are stapled to the grievances and there is a log that goes along with the petty cash which is kept by the Business Office Manager (BOM) and Receptionist. P. On 04/07/22 at 10:15 am, during an interview with the BOM and Receptionist, when asked to confirm if a reimbursement was provided to R #257, they confirmed no. 45426 Findings for R #7 Q. On 03/24/22 at 1:19 PM, during an interview and observation with family members for R #7, they stated the facility has been losing R #7's clothes. There have been times when they come to visit him and he was only wearing a brief. R #7's cell phone has also gone missing. They stated it has improved in the last two weeks and they no longer care about the missing clothes or the previously lost phone. They just do not want any more of his new clothes to go missing. They have replaced all his clothes, and he has pants. The family had brought more pants for R #7 today, and were observed marking the clothes using a marker to label with R #7's name. They also have replaced his phone and do not want his new phone to go missing. The family stated they had not filed a grievance because they only speak Spanish. The family stated they did not know they could update R #7's inventory to account for the new clothes and new phone.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 35632 Based on observation, record review, and interview, the facility failed to ensure that residents were: 1. Bathed according to the facility schedule and their preferences; 2. Staff were getting residents in and out of bed when they wanted. 3. Dressing residents according to their preference for 7 (R # 6, 7,19, 33, 50, 60 and 70) of 7 (R # 6, 7,19, 33, 50, 60 and 70) residents reviewed for choices. These deficient practices has the potential to prevent residents from maintaining personal hygiene per their personal preference and could likely cause residents to suffer a decline in their social interactions, enjoying activities, decline in social esteem or just being able to get out of bed. The findings are: Findings for R #6 A. Record review of the task list for showers indicated that R #6 shower days are Monday, Wednesday, and Fridays. B. Record review of the last thirty days in the task list indicated that R #6 was showered on 03/11/22, 03/16/22, refused on 03/18/22 and showered on 03/23/22. C. Record review of the weekly bath and skin report indicated that R #6 received a shower on 03/21/22 and 03/28/22. D. Per the above documentation R #6 received 6 out of 13 showers that she should have received for the month of March 2022. Findings for R #50 E. Record review of the resident task list for showers indicated that R #50 was to be showered on Tuesday, Thursday, and Saturday. F. On 03/22/22 at 3:53 pm, during an interview with R #50 stated forget showering, there isn't enough help with getting showers. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 04/01/22 at 10:17 am, during an interview with Certified Nursing Assistant (CNA) #6 she stated that sometimes they will have up to 15 showers per day. Of course, if you are working the floor alone you aren't ever going to get that amount of showers done, but if they have two CNA's they can almost get them done. She hasn't worked the floor alone very much. She stated that with R #50 she is mostly independent. She doesn't want to shower in the morning but if you approach her in the afternoon for a shower she will refuse because she doesn't want to miss bingo. Her shower days are on bingo days. When asked why not change her shower days, CNA #6 stated that she had not thought of changing her shower days and that was a good idea. H. Record review of the task list for the last thirty days from 04/06/22 revealed the following documentation: The only documented shower for R #50 was on 03/11/22. I. Record review of the weekly bath and skin report revealed that there was no documentation for the month of March 2022 for R #50. Findings for R #19 J. On 03/22/22 at 3:28 pm, during an interview with R #19 she stated that she goes weeks without showers. She was told by a CNA (unidentified) one time that she wasn't getting showered and other residents were because she didn't have family coming to see her and they did. She wasn't sure what her schedule was, she just knows that she isn't getting enough showers. She thinks she is supposed to get them three times per week. K. Record review of the Task List documentation for showers for the last thirty days indicated the following: On 03/11/22 at 14:59 (2:59 pm) it was marked with a yes for being showered. On 3/16/22 at 14:59 (2:59 pm) it was marked with a yes for being showered. On 3/18/22 at 11:46 am it was marked with refused shower. On 3/23/22 at 12:21 pm it was marked with a yes for being showered. Findings for R #33 L. On 03/23/22 at 8:32 am, during an interview with R #33 she stated that she does not get showered when she wants. She goes two weeks without a shower. She thinks that she doesn't get showers because it requires two staff to get her up and they don't have enough staff. M. On 03/23/22 at 8:32 am, during an observation, R #33 asked two CNA's to get her up and out of bed. She stated that she didn't get up yesterday because no one would get her up. The CNA's told her they had some other things to do and they would be back to get her up. N. On 03/23/22 at 9:32 am, during an observation, the same two CNA's came into the room again and stated that they still can't get her up yet. They told R #33 that they needed to go and change everyone and then they would get her up. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	O. On 03/23/22 at 11:41 am, during an observation of R #33, she was observed to still be in bed. P. On 03/23/22 at 3:12 pm, during an interview with R #33 she stated that she got up around lunchtime. Q. On 04/01/22 at 10:17 am, during an interview with Certified Nursing Assistant (CNA) #6 she stated that R #33 is a little harder to shower because she is a sit to stand. When they were short staffed she wasn't getting her showers regularly but she is getting them more now. R. On 03/29/22 at 11:32 am, during an interview with Social Services Director (SSD) he stated that he does receive a lot of complaints about showers. He stated that what he hears from staff about showering the residents, is that they are short staffed. He stated that sometimes a resident will want a shower at specific time like right before lunch. He will go to the resident's hall and ask the CNA's working that day if that resident can be showered before lunch and the CNA will say I will do my best I will try to get to it after I am done with so and so. S. On 04/01/22 at 11:44 am, during an interview with CNA #5 she stated that showering residents can range from 6 to 15 a day on the floor. She had 8 residents to shower today. She still has three to go. She stated that there are times they don't get showers done. CNA #5 stated that sometimes if there are a lot of call lights that will be the priority instead of showers. T. On 04/06/22 at 1:15 pm, during an interview with CNA #7, she stated that she has about 7 showers today. Most of them are done. She stated that sit to stands and Hoyer lifts are super challenging because it takes two people to shower them. CNA #7 stated that not all CNA's give showers, sometimes they just mark off that they gave them. 45426 Findings for R #70 U. Record Review of R #70's medical record revealed R #70 was admitted to the facility 11/16/21 with the following diagnoses: multiple sclerosis (disease that affects central nervous system by inflaming the protective covering of the nerve fibers making it difficult for the brain to send signals to rest of the body), contracture (abnormal shortening of muscle tissue, making the muscle highly resistant to stretching) of muscle, right lower leg; contracture of muscle, right lower leg; contracture of muscle, and right upper arm. These diagnoses are not comprehensive and do not include all of R #70's active diagnoses. V. On 03/21/2022 at 6:00 pm, during an observation and interview, R #70 was seen in bed on the 200 unit. She reported that she had been in bed since Wednesday and stated was supposed to get out of bed every day. If only one CNA shows up for their shift it messes up her showers, too because she needs two CNAs to assist her out of bed. She stated she understands why she is not being taken out bed due to staff shortages that it's just nice to get out of bed. R #70 would like to be out of bed at least 4 hours every day. Her shower days are Mondays, Wednesdays, and Fridays. She was supposed to get a shower today but did not get one. In addition, she would like to continue restorative therapy but has not been able to do so because the CNA who was initially doing it gets pulled to do the regular duties instead. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	W. On 04/04/22 at 3:25 PM, during an interview, CNA #7 stated there are times CNAs have not been able to get R #70 out of bed because she requires a Hoyer lift (name brand of an assistive device that allows patients to be transferred between a bed and a chair or other similar resting places, by the use of electrical or hydraulic power) because there are only 2 of us. She stated there are times when R #70 would not get out of bed for a week. There are CNAs who have not gotten R #70 out bed because she has a bad mouth (potty mouth-to be apt to use obscenities, vulgarities, or profanities in one's speech, especially at inappropriate times) or because she is a Hoyer lift. Those CNAs who had refused to transfer R #70, no longer work here or are usually agency staff who hardly work here. X. Record review of R #70's care plan dated 12/01/21 revealed the following: While in the facility, R #70 states that it is important that s/he has the opportunity to engage in daily routines that are meaningful relative to their preferences. Date Initiated: 05/18/21 Created on: 05/18/21, and R #70 will express satisfaction that her/his daily routines and preferences are accommodated by staff. Date initiated: 05/18/21. Created on: 05/18/21. Findings for R #60 Y. Record review of R #60's medical record revealed R #60 was diagnosed with the following diagnoses: quadriplegia (paralysis of both arms and legs), unspecified; weakness; and muscle weakness (generalized). These diagnoses are not comprehensive and do not include all of R #60's active diagnoses. Z. On 3/22/22 at 3:11 pm, during an interview, R #60 stated he was unclear about the last time he had been out of bed in his wheelchair. He reported to that he would like to get out of bed every day, but does not like to be in the chair very long because he starts to hurt. He used to ask every day to get in his chair but the CNAs will always tell him that they cannot put him in his chair because they don't have enough workers and have other excuses so he has stopped asking. When he was in his chair they would leave him in it too long and not return him to his bed when he is ready. He doesn't remember the last time he has asked to get in his wheelchair. AA. On 03/31/22 at 12:39 PM, during an interview, the Director of Recreations stated R #60 did not come to activities. He had told her he does not come to activities because the facility is short staffed and cannot lift him. He has also told her he would like restorative or range of motion services. BB. On 04/01/22 at 11:32 AM, during an interview, CNA #5 stated it was difficult to get to all the ADLs for the residents with only 2 CNAs on the floor. She stated it does not seem logical to get residents dressed for 2 hours and then change back into the bed for 2 hours. These preferences are difficult to accommodate as requested because there have been times when CNAs are working halls by themselves and have no help. Hoyer lifts cannot be done with only 1 CNA because it is unsafe for the resident and the CNA. CC. On 06/2022 at 1:15 pm, during an interview, RN #1 stated there are times when R #60 doesn't want to get out of bed. When he does get out of bed, 5 minutes later he will asking be put back in the bed, when he is out of the bed. Findings for R #7 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on interview and record review the facility failed to notify the on-call provider of multiple medication errors and keep the on-call provider notified of changes that were occurring with the resident and didn't allow the on-call provider to make informed decisions about the residents care and treatment for 1 (R #210) of 1 (R #210) resident reviewed. This deficient practice likely contributed to the residents death. The findings are: Resident #210 A. Record review of the facility five day follow up report dated 01/10/22 indicated that that R #210 was an [AGE] year-old female with a history of Congestive Heart Failure (CHF) with Ejection Fraction of 25% (ejection fraction is the amount of blood -- given as a percentage -- pumped out of a ventricle during each heartbeat, this evaluates how well the heart is pumping), diagnosed in December of 2021, history of chest pain, chronic pain, pleural effusion (an excessive collection of fluid in the pleural cavity, the fluid-filled space that surrounds the lungs), atrial fibrillation (A-fib is an irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart.), severe pulmonary disease (any condition that affects the blood vessels along the route between the heart and lungs), Hyper tension (HTN is high pressure in the arteries (vessels that carry blood from the heart to the rest of the body), GERD (gastroesophageal reflux disease is a digestive disorder that affects the lower esophageal sphincter (LES), the ring of muscle between the esophagus and stomach), among other comorbidities. Resident had an open reduction and internal fixation of a hip fracture in October 2021. The patient recently had significant fluid removed via a thoracocentesis (procedure to remove fluid or air from around the lungs) on 12/15/21. B. Record review of a five day follow-up dated 01/10/22 from a faciltiy reported incident (FRI) indicated that the evening of 12/27/21 a medication error occured where R #210 was administered the wrong medication. The medication administered to R #210 was as follows: Oxycodone (for pain), 10 mg (milligrams), Tramadol (for pain), 50 mg, Hydroxyzine (anxiety), 25 mg, Famotidine (antacid) 20 mg, Senna (for constipation) 8.6 mg, and Guaifenesin (mucinex), 600 mg. C. Record review of a progress notes dated 12/27/21 at 20:45 (8:45 pm), Wrong medication administered to PT (patient), DON (Director of Nursing aka Center Nurse Executive), Family notified. Will continue to monitor. There was no evidence that the Physician was notified of the medication error. D. Record review of the nursing progress notes dated 12/27/21 at 21:07 (9:07 pm) pt agitated and yelling out at this time. o2 (oxygen) sats (saturation) 57% on 5LPM (liters per minute) with a HR (heart rate) of 135, BP (blood pressure) 90/46. 911 EMERGENCY CALLED. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	E. Record review of the nursing progress notes dated 12/27/21 at 21:24 (9:24 pm) EMTs arrived on scene. EMTs stated that pt (patient) was stable and that 02 was empty and that the O2 tank was not hooked up properly EMTs took over pt care at this time along with other night nurse. EMTs stated to family that pt was stable and that maybe the nurses should collect a UA (urinalysis) because pt had a fever at this time as well and that we should check for a UTI (Urinary Tract Infection). Writer notified EMTs of current critical potassium lab of 2.9 (low patassium can result in fatigue, muscle cramps and abnormal heart rhythms); pt had reported episodes of CP (chest pain) previous shift. EMTs continued to speak with family and stated that family should keep pt here at facility because we could treat a UTI and low potassium here at the facility and that she would just be waiting in the waiting room all night anyway. Family chose to keep pt in facility against writers' (LPN #9) suggestion to be transferred to hospital. F. Multiple outreach efforst were made to R #210's family throughout the survey however never recevied a call back. G. Record review of the nursing progress notes dated 12/28/21 at 00:58 (12:58 am) pt found not breathing at this time. pt is a DNR (Do Not Resuscitate) as stated by husband. DON (CNE Center Nursing Executive) contacted. OMI (Office of the Medical Investigator) also contacted. H. Record review of medical chart vital signs for R #210 indicated that no vitals were documented in the resident chart after 8:31 am on 12/27/21. I. On 03/25/22 at 10:27 am, during an interview with the Center Executive Director (CED), he stated that during his investigation it was revealed that there were two contract nurses. LPN #9 asked that LPN #10 assist her with passing medication to a resident who was agitated. He went on to say that LPN #10 at some point became confused and passed the medications to resident (R #210) instead of R #183 . Both residents had family in their rooms and both residents were agitated. After LPN #10 came out of R #210's room she realizes that she gave the medication to the wrong resident. LPN #10 reported to LPN #9 right away and the physician on-call was called. The physician ordered Narcan. At that time after the phone call to the on-call, R #210's vitals were checked. Vitals were noted as low, and they provided oxygen to R #210 and called 911. The on-call was called again and dc/d (discontinued) the Narcan and ordered R #210 be sent out to the hospital. The EMT's arrived at the facility and facility staff informed them of the situation. The EMT's noted at that time that R #210's vitals were stable and recommended that R #210 stay at the facility since she was stable and would only be uncomfortable while she waited to be seen. Family was present in the room at the time with the EMT's and decided that if she was stable to not have her transported to the hospital. The CNE stated that staff were monitoring her and doing frequent vital checks even though the vitals were not written down and in R #210's medical record. Around two hours later she (R #210) was found unresponsive. Since she was DNR they facility staff did not try to resuscitate her. Family was called and notified. When asked if the physician should have been notified about the decision not send her out to the hospital, he stated that he didn't think that would have been necessary. It was the family's decision to not send her out. He confirmed that the monitoring of R #210's vitals should have been documented and they were not. J. Record review of R #210's medical record did not reveal that Narcan had ever been ordered or administerd to R #210 on 12/27/21. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	K. On 03/29/22 at 7:39 am, during an interview with RN (Registered Nurse) #1, she stated that she was called the night of the medication incident. She wasn't the CNE at that time. When she was called that night, she was told that there was a med error. She told the nurse that she needed to call the CNE. When asked who had signed out the medications that were given that night, she stated that LPN #9 signed them out. When asked if she had any information on whether the medications had been poured ahead of time, she stated it is not common to pop the medications and not give them right away, this is not how you pass meds. RN #1 also stated that Yes they should have called the physician back to let them know of the situation and get orders of what to do next. They never gave the Narcan, and she stated that from her understanding the family and the nurses wanted to send R #210 to the hospital but the EMT's changed the family's mind. Physician should have been called. L. On 03/30/22 at 9:46 am, during an interview with LPN #10 she stated that the night of 12/27/21 she was working the night shift. LPN #9 asked her to help passing medications on her hall. She agreed to help LPN #9. She stated that she got the medication out of the medication cart and went to R #210's room. She stated that at some point she had gotten confused about which resident she was passing the medications to because as soon as she had given the medications to R #210, she realized that it was the wrong resident. She told LPN #9 right away and the on-call provider was called. Shortly after that R #210's vitals were low, and the paramedics were called out. When they (EMT's) arrived, they were informed of the medication errors. The EMT's kept stating that the oxygen was hooked up wrong and that the reading they had before they were called probably wasn't right. They kept stating that she stable and didn't need to go the hospital. The family was present in the room at this time and the family told facility staff that if she was stable, they didn't want her to be uncomfortable in the ER waiting and the decision was made to keep her at the facility. She stated that she was not aware of the on-call provider being called again to ask for further direction and to inform of the decision that had been made to not send R #210 to the hospital. M. Multiple outreach attmept were made to talk with LPN #9 who no longer worked at the faiclity, however never received a call back. N. On 03/30/22 at 11:40 am, during an interview with Medical Director (MD), she stated that she looked through the logs that are kept of every call that comes through. She stated that on the evening of 12/27/21 someone from the facility called the on-call provider Nurse Practionier (NP #2) at 9:18 pm and the call was about abnormal vitals. The MD stated that she called NP #2 on 03/30/22 and asked about the call, and she was told by NP #2 that she didn't remember any conversation about multiple medication errors and ordering Narcan. She stated that in their record of phone calls this was the only call from the facility they received on 12/27/21. She stated that there was not a call made about R #210 on 12/26/22 or 12/28/22. She stated that everything is documented, and she believes these records are accurate. The MD also stated that Hydrazine, Oxycodone, and Tramadol should not be administered all at the same time and that this was also an issue. When asked what she would have done in this situation if she had been called, she stated that she would have ordered Narcan to be given and send out to the hospital. Even with Narcan it's not always a guarantee that it will work the way it should, and the resident would have need to be closely monitored. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	O. On 03/30/22 at during an interview with NP #2, she stated that she was the on-call provider the night of 12/27/21. The NP could not recall any details about what happened on the evening of 12/28/22. She did not have any notes about a medication error, just that R #210 had abnormal vitals. When informed of what happened, she stated that she would have expected Narcan to have been given and that if there was an order to send the resident out to the hospital that she would have expected it to be followed. P. On 03/30/22 at 6:39 pm, during an interview with Certified Nursing Assistant (CNA) #8 she stated that she was working the night of 12/27/21. She stated that R #210 was agitated the night and that family (granddaughter) was with her in her room. The nurse that night on the hall was LPN #9. CNA #8 stated that she took her vitals and proceeded to go out on the floor to do check and changes. She stated that LPN #9 was doing a bed change with a resident and had asked R #10 to come down and help her with medications. She remembers LPN #10 asking her to keep an eye on her (R #210) this was after the medication error. R #210's vitals were really low after the medication was given. One of the nurses set her up with O2 (oxygen) and her levels went back up. EMT's arrived and they weren't very professional. She was in an out of the room because she had a lot of residents on the hall and was caring for them too. She remembers that the granddaughter wanted to send her out to the ER, but the paramedics stated she was stable. She was writing the vitals on a piece of paper, but she doesn't know where it went. CNA #8 stated that she went back in to check on R #210 and she wasn't breathing and had passed. She called LPN #9 to the room and the EMT's were called back. She stated that R #210 was pulling out her oxygen and she would have to put it back in. She stated that she checked on her often. She stated that she remembers R #210 being lethargic and agitated at the same time. When asked if she was given any specific instruction on how to monitor R #210 after the medication error, the CNA #8 stated no. This failure resulted in an Immediate Jeopardy (IJ) being called on 03/31/22 at 4:30 pm with a scope and severity at level J. Identification/Correction of the IJ All residents have the potential to be affected by inconsistently completing assessments, monitoring, and notifying the physician when change of condition occurs. Licensed nurses assessed current residents residing in center on 03/31/22 to determine presence of a medical change in condition. Identified issues were reported to MD (Medical Director) for further direction and medical orders. Registered nurse reviewed current residents progress notes on 03/31/22 to determine presence of a medical change in condition with steps taken to provide care related to identified medical need. Identified changes of medical condition not reported to MD will be reported and medical orders followed. The Center Nurse Executive re-educated current licensed staff regarding policy for resident change in condition. The Education includes: -Documentation must occur for all change in condition. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The eInteract change in condition assessment needs to be completed filled out with all the details of what happened. -The provider, nurse manager and family must be notified immediately. If the family is present, we still must notify the provider of all changes, including if family is present, we still have to notify the provider of all changes, including if the POA (Power of Attorney) would like nothing to be done about the situation. The provider will decide what needs to happen. -Any and all vital signs need to be reviewed and documented immediately. -Orders need to be put into the system, even if it was after you have taken care of the resident because it was an emergency. -CNA's need to document the vitals that they take and nurses need to ensure they have completed it. -Monitoring needs to continue to happen and documented if the resident is still in the building until we know they have stabilized. -If the condition changes again, or the plan for the resident changes in anyway, the provider and family need to be notified again. Documentation needs to reflect the change, and those notifications occurred again. The removal of the IJ occurred on 04/01/22 at 2:30 pm which was verified on site.

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F 0686 Level of Harm - Minimal harm or potential for 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** 40795 Based on interview and record review, the facility failed to maintain a process of accurately completing skin assessments and providing notification of a wound to the wound care nurse and primary physician for 1 (R #96) of 3 (R #'s 31, 96, and 257) residents reviewed for pressure wounds. This deficient practice could likely result in a delay in treatment and lack of skin integrity. The findings are: A. Record review of the facility's policy titled Skin Integrity Management, revised 06/01/21, revealed the Implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed. Further review revealed that practice standards should include 2. Complete comprehensive evaluation of the patient upon admission/re-admission to the center. 2.1 Complete risk evaluation on admission/re-admission, weekly for the first month, quarterly, and with significant change in condition. 3. Identify patient's skin integrity status and need for prevention intervention or treatment modalities through review of all appropriate assessment information . 3.2 Perform skin inspection on admission/re-admission and weekly. Document on the Treatment Administration Record (TAR) or in Point Click Care (PCC). 7. Notify physician/APP (Advanced Practice Provider) to obtain orders. 8. Notify patient, resident representative of plan of care. B. On 03/23/22 at 12:23 pm, during an interview with the family member of R #96, she explained My husband is the Power of Attorney for her but he is hard to get a hold of due to his job so, I have been placed as the first emergency contact for her. I work for PACE [An all inclusive health care management program which includes the resident's primary physician] and I see that they have a hard time communicating with PACE so, I often help in the communication. They are constantly short staffed, especially on the weekends. I go to visit her every weekend. I have gone in there and she is wet [soiled brief]. She has a wound on her left heel. PACE ordered heel protectors for her but they don't put them on her. I have to call the CNAs (Certified Nurse Assistant) to ask them to change her [brief]. C. Record review of the PACE care plan, last reviewed 11/17/21, revealed Moderate risk for pressure ulcer based on Braden score of 13 [a Braden assessment is an evaluation of the patient to determine the risk for developing a pressure ulcer. A score of 13 indicates that the resident is at moderate risk to develop a pressure ulcer]. Left heel pressure sore- wound healed 11/2021 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Record review of the Electronic Health Record (EHR) revealed that R #96 was admitted to the facility on [DATE] with the following pertinent diagnoses: type II diabetes mellitus (A chronic condition that affects the way the body processes blood sugar) with chronic kidney disease (damaged kidneys that are unable to filter blood they way they should), chronic kidney disease stage III (there are 5 stages of kidney disease, each stage signifies the functional abilities of the kidneys, stage one would be the highest functioning and stage five is the lowest functioning stage), cognitive communication deficit (difficulty in maintaining a thought process to use language to communicate), unspecified abnormalities of gait and mobility, weakness, hemiplegia (muscle weakness on one side of the body) and hemiparesis (partial muscle weakness) following cerebral infarction (a result of disrupted blood flow to the brain) affecting unspecified side, and unsteadiness on feet. Further review revealed that she was transferred to the hospital on 03/06/22 for complications of a recent diagnosis of Clostridioides difficile (a bacteria that causes severe diarrhea and inflammation of the colon) and then returned on 03/10/22. E. Record review of physician orders revealed the following skin care related orders: 01/11/22, monitor & elevate bilateral heels as tolerated. Apply lotion/A&D ointment as needed every 12 hours as needed for Discoloration on bilateral heels 03/22/22, apply skin prep to bilateral heels and ensure that heels are offloaded. Monitor skin for any changes to skin integrity. Every day shift for skin care 03/24/22, Wound care order to sacrum: Cleanse area with wound cleanser or NSS [Normal Sterile Saline], pat dry, apply medihoney [an ointment that is used to reduce bacteria and promote healing in a wound] and calcium alginate [an ointment that removes moisture form wounds to promote healing], spray skin prep on periwound then cover with protective dressing as needed 03/25/22, Wound care order to sacrum: Cleanse area with wound cleanser or NSS [Normal Sterile Saline], pat dry, apply medihoney and calcium alginate [an ointment that removes moisture form wounds to promote healing], spray skin prep on periwound then cover with protective dressing. Every day shift. F. Record review of the EHR revealed documented skin assessments as followed: Skin assessment, dated 10/21/21, revealed no identification of wounds or use of external devices (braces, casts, prosthetic equipment) Skin assessment, dated 10/28/21, revealed no identification of wounds or use of external devices Skin assessment, dated 11/04/21 revealed no identification of wounds or use of external devices Skin assessment, dated 11/11/21 revealed no identification of wounds or use of external devices Skin assessment, dated 02/06/22, revealed no identification of wounds or use of external devices Skin assessment, dated 02/13/22, revealed no identification of wounds or use of external devices Skin assessment, dated 02/20/22, revealed no identification of wounds or use of external devices (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skin assessment, dated 02/27/22, revealed no identification of wounds or use of external devices Skin assessment, dated 03/13/22, revealed no identification of wounds or use of external devices Skin assessments dated 03/20/22 revealed a new wound was identified and noted to be on the left heel. Skin assessment dated [DATE] revealed a wound was identified, a pressure wound on the coccyx. G. Record review of Shower sheet, dated 03/22/22, revealed that peeling was identified on her sacral region. H. Record review of nursing progress notes, dated 03/23/22, revealed that a skin assessment was performed and a stage 3 pressure ulcer (stage three, out of four, is a wound that is a result of unrelieved pressure where all layers of the skin are lost and the first layer of fat is visible with the naked eye) was identified on the left buttock which measured 3x3.5x.2 cm (centimeters) and an additional stage 3 pressure ulcer on left buttock measuring 1.5x2.5x.2 centimeters. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. On 03/31/22 at 9:45 am, during an interview with LPN (Licensed Practical Nurse) #13, when asked to describe the sacral wound on R #96, he explained, It started off as a moisture associated wound. We thought she had C. Diff [Clostridioides difficile, a serious bacterial infection that causes a disruption of the normal bacteria in the colon]. She had a lot of diarrhea. In December, the Certified Nursing Assistants (CNAs) were neglectful and that's how she developed this moisture associated wound. A lot of the residents would tell me [about the neglectful CNAs]. She was left with a lot of moisture. She started off with a lot of tenderness. You could feel the tailbone and she had a lot of yeast substance around her peri area, which lead to a rash around her brief. When her bed was soiled, her back was irritated. We figured out that the day shift would report the night shift and we figured out which CNA was responsible. [Name of previous Center Nurse Executive (CNE)] let both CNAs go. [Name of R #96] her wound is healing, it has gotten smaller. She has no pain. [Name of R #96] has had that wound for about 3-4 months. The C. Diff is a newly discovered issue for her. She went to the hospital about 2-3 weeks ago and she was dehydrated with a UTI [Urinary Tract Infection]. When asked when the sacral wound was discovered, he explained It was discovered some months ago. When asked if the family member of R #96 was informed of the sacral wound, he stated It was not mentioned to [name of R #96's family member]. During that time [Name of LPN #8] was going into the wound care position. Our old Nurse Practitioner (NP) was leaving and we were onboarding our new NP. There were a lot of changes. [Name of current NP] was aware of her wound but our physicians let the PACE doctors do the work. PACE did not know about the wound. We put it in as a standing order for her wound care, which is basic, for example, lets say somebody accidentally scratched there skin, we would put an order in for it. Because it wasn't from PACE we just had an order to put a dressing on it. I'm pretty sure that nobody let PACE know [about the sacral wound]. I don't know why nobody told PACE. When asked to explain the process to inform PACE, he described You call the receptionist and tell them about the patient and they will redirect you to the nurse who cares for her. The PACE nurses are supposed to come in but I have never seen anybody from PACE. She has a lot of video calls and they have a whole team who gather for an hour. Before the pandemic, PACE would go to them and do therapy and everything but now they just video calls. When asked to discuss the progression of the wounds, he explained The nurse and CNAs would know about it. When I changed her wounds, I depend on the CNAs. I would try to catch her on her shower days to do her wound treatment. When they get her up, I would do it then. They would help me as they are working with her. Its up to the nurse and CNAs to keep an eye on it. When we have med techs its hard for us to go to each residents. With med techs, its hard to put an eye on residents. We depend a lot on residents to tell us if residents have new wounds or new skin issues. When asked if the skin assessments would help with identifying wounds, he stated, If the nurse is not doing it, its hard to know. Because of how short staffed we are, I have been working on 100 hall and when I get back to the 200 hall, the wounds will not be looked at as scheduled. Due to staffing, the nurses will split a hall, so they will chart that they didn't get to the wounds. And then the wounds will go about 4 days without a wound change. If they [residents] are alert, they will let us know. For the others, its hard to follow-up to know if its getting worse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	J. 03/31/22 01:52 pm, during an interview with LPN #8, when asked to describe R #96's sacral wound, LPN #8 explained, When I checked her on the 23rd [03/23/22]. She had a stage 3 [pressure ulcer] . I don't know if upon readmission, she had it or not. The first time I saw her was the 23rd . It was identified on the 20th [03/20/22] but I was not notified. When asked how a notification should occur, she explained whoever discovers any wounds should do a basic wound care order and notify the CNE [Center Nurse Executive] and then let me know. When asked if the physician should be notified, she stated I don't know if they should notify the physician. When asked if treatment orders should come form the physician, she stated, Yes, they should come from the physician. When asked how orders derived for R #96, she explained, I put new orders in and they came from the NP. When asked if she receives notification of newly discovered wounds, she stated, I don't get notified of new wounds. If I don't get notified, then nothing else happens [further wound care]. I feel like the breakdown is . most of our new admissions have wounds and the first eye is supposed to put orders in for the wounds. When asked how the weekly skin assessments should be done, she stated, The skin checks should be completed and not just look at someone else's previous skin assessment. Not copy and paste it into the new skin assessment or if they do it at all. K. On 04/04/22 at 2:39 pm, during an interview with CNA #7, when asked to describe the wound on R #96's sacral area, she explained, She was starting to get a new wound, another CNA and I caught that wound. That CNA told a nurse that she had a open wound and the nurse said we are aware and instructed us to put barrier cream on it. This happened about three weeks ago. The nurse said it was not a big wound and she made it sound like the rest of the nurses knew about it. When we told a different nurse about it she said 'oh, no this needs to be covered'. This happened about one week after we told the first nurse. Last time I saw her R #96 was when they were going to send her out to the hospital. On her butt, it looked like rug burn. Every time we cleaned her, skin would peel off. L. On 04/04/22 at 3:58 pm, during an interview with RN# 14, when ask to describe R #96's sacral wound, RN #14 stated, She had a darkish wound on the back side and it was kind of discolored. Sometimes it was better than other days. It was red in the center and had eschar [dead skin that eventually sloughs off healthy skin after a skin injury]. Sometimes we put triad past [zinc oxide] and sometimes med honey to get rid of that eschar. Last time it had eschar on. It had about a quarter size of eschar and it was red around it. I know she [R #96] is incontinent and she has a lot of urine. She's always been red in that area. I have never seen it [the sacral wound] open. I noticed it was black in the center spot, about a couple weeks before she went to the 100 hall. If its black it means its starting to get necrotic. M. On 04/05/22 at 11:12 am, during an interview with Unit Manager, when asked to explain how the skin assessments get completed, the Unit Manager explained They [nursing staff] are suppose to go in and complete it according to how it should be completed. When asked if they are getting done, she explained Not as they should be. I am trying to find out what the issue is. When asked if she is aware of R #96's wound she explained that R #96 was readmitted with it [on 03/10/22]. N. On 04/06/22 at 11:29 am, during an interview, when asked if skin checks are audited, RN #1 explained The skin checks have not been getting done or closed [completed] for about a month and a half.

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	325064	A. Building B. Wing	04/07/2022

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interviews, the facility's Administration knew or should have known of the following deficient practices occurring in the facility: 1. That a significant medication error occurred and the investigation didn't reveal the source of the problem. 2. Unable to participate in the recertification survey due to Center Executive Directors license expiring. 3. Not making significant corrections with the laundry department after being aware of the issues with residents personal belongings. 4. Not having Quality Assurance Performance Improvement (QAPI) documentation indicating what QAPI was working on. 5. Not having a licensed Social Worker. These deficient practices have led to a failure in Administration and Management could likely affect the residents physical, mental, and psychosocial well being by not addressing their needs for all 111 residents. The findings are: Medication Error A. On [DATE] at 1:11 pm, during an interview with Center Executive Director (CED), when asked if the medication error that occurred on the evening of [DATE] for R #210 resulted from medications being pre-poured before they were given, he stated he didn't know. When he interviewed LPN #9 he did not ask that question. He also confirmed that he only spoke to LPN #9 on the phone and did not get a written statement from her. He stated that he was aware that the, 6 R's Right Resident, Right Medication, Right Route, Right Dose, Right Time and Right Indication of Use for medication administration were not followed. The CED stated that he was more focused on what happened after the medication error occurred, because he felt like that was more important than the actual error and why it happened. CED License: B. On [DATE] at 10:18 am, during an interview with the Acting Center Executive Director (CED) she stated that the current CED is not here, [in the facility] because his license expired. C. On [DATE] at 10:22 am during an interview with Acting Center Executive Director #2, he stated that the current CED of the facility isn't in the facility because of his license. He stated that he didn't have enough CEU's [continuing education unit] to re-apply for his license or was denied license renewal due to a lack of CEU's. He is currently working on getting his license re-instated. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Laundry issues: D. On [DATE] at 8:45 am, during an interview with Center Executive Director (CED), he stated that he is aware of the issues in the laundry. He stated that apparently there are some personnel problems between laundry and other staff. He stated that they are talking about getting mesh bags per each resident to put their clothes in and they get washed in the mesh bags. That hasn't happened yet. E. On [DATE] at 10:35 am, during an interview with the Social Services Director (SSD), he stated that he handles the grievances when they come in. He will get the grievance and assign it out to the appropriate department. He has received lots of complaints/grievances about laundry. the problem that he has with the laundry is that he is not sure that they actually ever look for the missing clothing. SSD stated that he will go there (laundry) himself and look. Sometimes the laundry staff will get mad at him or anyone who goes to laundry to look for missing clothes. He stated that laundry tells everyone that there are no names on the clothing but that isn't true, most of them are clearly marked. Each resident's clothes have their name in big letters on it. He stated that 90% of the grievances are about missing clothing. He has told the Center Executive Director but nothing ever gets done or changes. Quality Assurance Performance Improvement (QAPI): F. On [DATE] at 2:23 pm, during an interview with Center Executive Director #2, he stated that they were unable to locate any QAPI information. He is not aware of any sign in sheets, who has attended, how frequently the meetings are taking place and what has been worked on in the QAPI process. He stated that since [DATE] he was unable to locate any information. G. On [DATE] at 2:28 pm, during an interview with Registered Nurse #1, she stated that she only attended the QAPI meetings while she was the acting Center Nurse Executive. She stated that the types of issues that being worked on in her department was call lights being answered timely and some infection control issues. H. On [DATE] at 2:34 pm, during an interview with Unit Manager #1, she stated that she has been here starting in [DATE] to the present. She didn't really re-call what was being discussed in QAPI. I. On [DATE] at 2:38 pm, during an interview with Activities Director, she stated the CED will ask them what they think needs improvement and they will get into their groups and work on things in their area that need improvement. She couldn't state who attends because sometimes people are on zoom when they attend and wasn't sure if anything was being written down. Certification of the Social Services Director: J. Record review of the extended survey binder provided by the Center Executive Director #2 (CED) indicated that the license on file for the Social Services Director was the previous SSD license and not the current SSD. K. On [DATE] at 10:18 am, during an interview with the Acting Center Executive Director (CED), he/she is currently licensed for 124 beds and because the facility is licensed for over 120 beds she confirmed that their current Social Services Director (SSD) was not licensed or certified and they would need to work on getting the SSD licensed.

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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** 35632 Based on record review and interview, the facility failed to ensure for 7 (R #6, 15, 33, 46, 47, 50 and 61) of 7 (R #6, 15, 33, 46, 47, 50 and 61) residents reviewed for showers/skin integrity and activities of daily living (ADL's), that the residents medical records were complete, accurate and consistent These deficient practices have the potential to negatively impact the continuum of care by: 1. Not completing shower/skin integrity reports which could cause skin issues to not be addressed. 2. Nursing staff not identifying resident needs which could likely cause asphyxiation [a deficient supply of oxygen to the body, due to abnormal breathing]. 3. A resident not receiving the assistance needed due to missing records and the records not being accurate. The findings are: Findings for R #6: A. Record review of the weekly bath and skin report indicated the following: December 2021 there were two documented. January 2022 there were none provided. February 2022 there were none provided. March 2022 there were three documented. Of 17 possible weekly bath and shower reports only 5 were provided. Findings for R #33 B. Record review of the weekly bath and skin report indicated the following: December 2021 there were three documented. January 2022 there were two documented. February 2022 there were none provided. March 2022 there were none provided. Of 17 possible weekly bath and shower reports only 5 were provided. Findings for R #50 C. Record review of the weekly bath and skin report indicated the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	December 2021 there were three documented. January 2022 there were two documented. February 2022 there were none provided. March 2022 there were none provided. Of 17 possible weekly bath and shower reports only 5 were provided. Findings for R #46 D. Record review of the weekly bath and skin report indicated the following: December 2021 there are three documented. January 2022 there are three documented. February 2022 there were none provided. March 2022 there was one documented. Of 17 possible weekly bath and shower reports only 7 were provided. Findings for R #47 E. Record review of the weekly bath and skin report indicated the following: December 2021 there was one documented. January 2022 there was one documented. February 2022 there were none provided. March 2022 there were three documented. Of 17 possible weekly bath and shower reports only 5 were provided. F. On 04/01/22 at 10:17 am, during an interview with Certified Nursing Assistant (CNA) #9 regarding charting and shower sheets, she stated there isn't enough time to document, so if something were to not get done it would be charting/documenting. She stated that she is currently having a problem with her tablet and not being able to log in and so she had to go take care of that issue. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 04/06/22 at 11:54 am, during an interview with Registered Nurse #1, she stated that documentation had been discussed a lot. RN #1 stated that they have tried everything with staff about the importance of documenting. Nothing seems to work. There are issues for the Certified Nurse Aides (CNA) with their tablets not working. She stated that the CNA's have told her that the tablets not working is the #1 issue why they didn't document. She stated that micro-managing them hasn't worked either. She agreed that the documentation was sparse. 45426 Findings for R #15 H. Record review of R #15's medical record revealed in a care plan meeting note dated 08/03/18 that he is a NPO (Latin for nothing by mouth) resident. I. Record review of R #15's Kardex (a system of communication and organization used in nursing that helps long term care facilities document patient and resident care summaries) under Eating stated Encourage resident to consume all fluids during meals. Offer/encourage fluids of choice. Free H20 [water] as ordered. J. On 3/29/2022 at approximately 1:45 PM, during an interview, Kitchen Manager, KM, confirmed the Kardex for R #15 was not correct. R #15 is an NPO resident and should not be encouraged to consume liquids. K. On 3/30/22 at 4:08 PM, during an interview with the Registered Dietician (RD), she confirmed that R #15 is an enteral feed (a method of supplying nutrients directly into the digestive tract) resident. He should not be taking in hydration orally and he is NPO. Free H2O means the amount of water needed to flush the tubing for his enteral feeding and that counts towards his hydration. The Kardex is not accurate. Findings for R #61: L. Record review of R #61's medical record revealed he was admitted to the facility on [DATE] with the following diagnoses: abnormal weight loss; dysphagia (a condition with difficulty in swallowing food or liquid) following cerebral infarction (a stroke of the brain); muscle weakness (generalized); major depressive disorder, recurrent, moderate (repeating episodes of depression, after periods of time without symptoms that is the next level up from mild depression which can cause problems at home and work); unspecified lack of coordination, and cognitive communication deficit. This list is not comprehensive and does not include all of R #61's active diagnoses. M. On 03/28/22 a Record Review of R #61's Care Plan entry created 03/09/2022 revealed the following: During my 'Preferences for Customary Routine' Interview, there were daily routine preferences noted as important. The most important things for the center staff to know about my preferred daily routine are: Please sit up/get me into chair for all meals, as well as set up my meals with lids open, and utensils readily within reach. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date Initiated: 03/02/2022 Created on: 03/09/2022 N. Record review of R #61's Kardex revealed that the above listed preferences had not been updated and listed in the Kardex. O. On 03/24/22 at 12:09 PM, during an interview and observation, R #61 and a family member stated that he has difficulty reaching for his utensils if they are out of his reach. The lids also need to be opened on his food and his beverage cartons opened. It was observed that his juice cartons had not been opened, and the lids had not been removed from his yogurt. R #61 also informed he could not eat anything in the disposable plastic bowls or the re-usable plastic serving cups because he would spill the food on himself. He was unable to lift them, and they slide across the table, when attempting to scoop food out of them. He was unable to get he food out of the plastic containers. R #61 was observed eating one-handed and struggled to push the food onto his spoon. The food would move on his plate. It was observed R #61 was not able to use his other hand to assist with eating. R #61 stated his other arm was crippled (severly damaged or malfunctioning) and he was unable to use it. It was observed that R #61 struggled to reach items on the opposite side of his tray. P. On 3/30/2022 2:15 PM, during an interview, CNA #10 stated there are many times when the CNAs are unable to see the ADLs on the computer-they are unable to log in. She did not know what a Kardex is. Q. On 03/30/22 at 4:08 PM during an interview, RD stated R #61 had not informed her of his inability to eat out of plastic containers. She had recently met with him made some adjustments to his care plan. RD stated she does not know who is supposed to update a resident's Kardex. R. On 04/01/22 at 10:14 AM, during an interview, CNA # 5 reported she is unable to see the ADLs on the Kardex due to being a restorative CNA. She is unable to train new CNAs on logging into the Kardex to log the ADLs due to not having access. She was working as a CNA on the 400 unit at the time of the interview. S. On 04/01/22 at 2:07 PM, during an interview, CNA #15 reported not being able to access the Kardex system to log the completed resident Activities of Daily Living (ADLs) resident assisted tasks. He had been working at the facility for 4 days. T. On 04/06/22 at 11:10 AM, during an interview, RN #1 reported she has not been entering programming or tasks (ADLs) into the Kardex. During an earlier interview on 04/01/22 at 12:46 PM, she stated September 2021 was the last time she had entered ADLs into the task list. U. On 04/07/22 at 9:22 AM, during an interview, Minimum Data Set (MDS) Coordinator stated she was responsible for completing the MDS and filling out her area of care plans but she was not responsible for the Kardex. She does not know who is supposed to update the Kardex and thinks it may be nursing. /