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	11/04/2022

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 0580 Level of Harm - Actual harm 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** 39822 Based on record review and interview, the facility failed to notify the physician and family for 1 (R #17) of 1 (R #17) resident reviewed for falls. This deficient practice likely resulted in a delay in identification of a hip fracture and unnecessary pain. The findings are: A. Record review of the face sheet revealed R #17 was admitted to the facility from a local hospital on 03/03/22 with a primary diagnosis of left femur [long bone in upper leg extending from the hip to the knee] fracture and a secondary diagnosis of dementia [a group of symptoms that affects memory, thinking and interferes with daily life] without behavioral disturbance [a pattern of disruptive behaviors]. B. On 11/01/22 at 2:40 pm, during an interview with R #17's husband and Power of Attorney for Health Care [legal document that empowers a specific individual to make decisions on your behalf concerning your medical condition, treatment, and care] (HCPA) decisions, he revealed, on Tuesday [09/27/22] [first name of hospice nurse for R #17] called and said his wife had a fractured]broken] left hip the upper part of the upper bone of the thigh that extends from hip to knee] and pelvis [a break of the bony structure of the pelvis (to include sacrum, hip bones and tailbone]. I go to the nurses station and said, 'Did my wife fall?' It was one of the traveling nurses [he addressed] and after she looked in the computer [looking for information about R #17 falling], she said, no. The nurse next to her [at the nursing desk], [first name of Registered Nurse (RN) #10], then told him his wife had fallen out of bed on Friday [09/23/22] and she [RN #10] didn't write it up [did not write an incident report - a document that describes an incident that occurred in which a resident might be harmed and where you document calling the provider and the family to notify of the incident]. C. On 11/01/22 at 4:30 pm, during an interview with R #17's hospice nurse, she revealed, she saw R #17 on 09/26/22, that she [R #17] had a dramatic change in status, tremendous pain and could not bear weight on her left leg. She asked for X-rays [to be obtained] and when the results were given to her [on 09/27/22] she called the nurse at the facility [RN #10] and was told [by RN #10] that R #17 had been found on the floor by her bed around dinner time [4:30 pm] on Friday evening [09/23/22] they [facility staff] found her on the floor by her bed, they thought she had just tried to get into her wheelchair (w/c) by herself to go to dinner, she assessed her and thought she was fine [was not injured] so they put her in to her w/c and gave her dinner. (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

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 11/04/2022
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	D. On 11/03/22 at 11:20 am, during an interview with Registered Nurse (RN) #10 [nurse who was caring for R #17 when she fell on [DATE]] she revealed, I just got too busy and let it slip my mind [to report the incident]. No, I didn't call the husband or the doctor that day. [She confirmed the husband and medical provider were not informed of R #17's fall on 09/23/22 until 09/27/22]. E. On 11/03/22 at 1:35 pm, during an interview with the Nurse Practioner caring for R #17 at the facility she revealed that the residents fall on 09/23/22 had resulted in an acute [new] hip and a pelvic fracture. She had been informed about the hip fracture after the resident had X-rays done on 09/27/22 and she had read the report from the radiologist for the first time today [11/03/22] and it was then she realized the resident also had a pelvic fracture.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35632 Based on record review and interview, the facility failed to submit and verify that the state survey agency received the five day follow-ups for 6 (R #s 21, 22, 23, 24, 25 and 26) of 6 (R #s 21, 22, 23, 24, 25 and 26) residents reviewed for reporting. This deficient practice could likely result in the state agency not having all of the information needed, leading to complaints and allegations not being investigated by the State Survey Agency. The findings are: A. Review of a complaint that was assigned on 11/01/22 indicated that there were six facility reported incidents that the state survey agency did not receive a five day follow up. B. On 11/02/22 at 2:20 pm, during an interview with Certified Executive Director (CED), she stated that she does not have emails or fax cover sheets for the six 5-day follow ups that were requested. C. On 11/03/22 review of an email that was sent from the State Agency Complaints Department indicated that 23 follow up reports/5-day follow ups were submitted to them on 10/26/22 by the facility. There were 6 of those follow up reports/5 day follow ups that were not sent, were for the wrong incident, or duplicates of other FURs (follow up reports) the state survey agency had already received. The email confirmed that the state survey agency did not receive the follow ups for 6 FRI's that involved the following: R #21 incident took place on 08/04/22 and had to do with missing money and a bag of chips. R #22 incident took place on 10/19/22 when R #22 had a fall out of bed. R #23 incident took place on 10/14/22 a complaint that CNA's are being rough. R #24 incident took place on 10/17/22 unexpected death. R #25 incident took place on 10/13/22 when R #25 had a laceration on right calf. R #26 incident took place on 08/11/22 when R #26 had an unexplained bruise on her arm.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview, the facility failed to ensure that a thorough investigation was completed and provided to the state survey agency for an incident involving 1 (R #24) of 6 (R #21, 22, 23, 24, 25, and 26) residents reviewed when the facility failed to interview all staff that had been working with the resident prior to the change in condition. If the facility is not conducting through investigations of incidents with adverse outcomes to residents, then the facility may fail to identify abuse and neglect and not implement corrective measures to prevent future occurrences. The findings are: A. Record review of the face sheet for R #24 indicated the following diagnosis: end stage renal disease (advanced state of kidney loss of function that causes changes in urination, fatigue, swelling of feet, high blood pressure, and loss of appetite), type 2 diabetes (the body doesn't use insulin properly causing health concerns), morbid obesity (overweight), acute respiratory failure (meaning that the arterial oxygen, carbon dioxide, or both cannot be kept at normal levels), obstructive sleep apnea (most common sleep-related breathing disorder causing a person to repeatedly stop and start breathing while you sleep), and personal history of sudden cardiac arrest (a sudden, sometimes temporary, cessation of function of the heart). B. Record review of a 5 day follow up/state reportable dated [DATE] indicated that R #24 was having some breathing difficulties (evening of [DATE]) when Registered Nurse #5 came into the room for rounds. The incident report stated that R #24 passed away on [DATE] after he lost consciousness and RN #5 and the paramedics were unable to revive him. C. Record review of the progress notes dated [DATE] indicated the following: upon getting to Resident's (R #24) room to administer his night medication, I noticed that Resident was sitting helpless on a recliner couch. I noticed that he was having difficulty breathing . His oxygen was on 5 LPM (liters per minute) but he is saturating (amount of oxygen that is in your blood stream) at 81%, and I raised it above 5 LPM, but the concentrator could not reach between 6 liters to 10 liters . I and my CNA, (Certified Nursing Assistant) (name of CNA) immediately went to supply room to get a concentrator that can administer above 6 liters. It was on the process that the CNA called me. The moment I went into the room, I saw (resident) in a coded form (not breathing, no pulse). I jumped action for CPR (Cardio Pulmonary Resuscitation) by initially doing chest compression. I yelled to the CNAs to call other nurses and was yelling to call 911 . Paramedics were called, and they arrived within ,d+[DATE] minutes . The two CNAs (name of) and (name of) (that were working with RN #5 the evening of [DATE]) later told me (RN #5) that they both noticed (name of R #24) difficulty breathing on Sunday ([DATE]) and told the nurse, who promised to chart. And I directed the two CNAs to write what they said and it has submitted to the DON's (Director of Nursing/Certified Nursing Executive) office. D. Record review of the vitals for R #24 indicated the following: -On [DATE] at 13:04 (1:04 pm) oxygen saturation was at 92.0 % (normal range) on room air. (without oxygen) -On [DATE] at 02:03 am (time it was likely documented) oxygen saturation was 93.0 % on room air. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On [DATE] at 23:24 (11:24 pm the time it was likley documented in the residents record) indicated that his oxygen saturation was 81.0 % via nasal cannula. E. Record review of the written statement by CNA #5 indicated the following: I (name of CNA #5) to herby attest to the following as best as I recall on the date of [DATE]. (name of R #24) I noticed during my shift that night had small trouble breathing when in his chair as well as I believe one time during the night I mentioned this to the night nurse. Signed and dated on [DATE] by CNA #5. F. Record review of the written statement by CNA #6 indicated the following: Sunday (October)16 night shift I only heard (name of R #24) chocking, and gasping for air to breath that's all of what I heard and I (name of CNA #6) let the nurse know about (name of R #24) and that he's breathing funny. Signed by CNA #6. G. Record review of a 5 day follow up/state reportable dated [DATE] did not investigate the concern voiced by the two CNA's about the breathing difficulty that R #24 was having on [DATE]. H. On [DATE] at 3:01 pm, during an interview with the Certified Nursing Executive (CNE) indicated the following: CNE stated that she did receive the statements from the two CNA's. When asked about the investigation that was done based on the statements that R #24 was having difficulty breathing the day prior ([DATE]), CNE stated that she spoke with CNA #5 but not CNA #6 and not the nurse that the CNA's reported the breathing difficulty to. CNE stated that she saw R #24 on the day he passed ([DATE]) and he seemed fine to her and he wasn't having any issues and his vitals had been fine that day ([DATE]).She stated that during the day on [DATE] the unit manager and several others did not notice any differences in R #24 that day, and RN #5 did not indicate that he was having issues earlier in the day. The CNE stated again that no one voiced any concerns about R #24 and because no one voiced any concerns that this concluded her investigation. She confirmed that she only spoke to one CNA and did not speak with the other CNA, or the nurse that the CNA's had said that they reported the breathing issues to. She also stated that she did not have any statements or written documenation of the interviews that she conducted around the two CNA statements. I. On [DATE] at approximately 11:35 am, during an interview with the Certified Executive Director (CED) she stated that she did not know anything about the two statements that had been made by the CNA's. She stated that she would have liked to have seen more of an investigation into what the CNA's had reported. J. On [DATE] at 9:45 am during an interview with RN #5, he stated that after R #24 had passed, both of the CNA's (CNA #5 and #6) had come to him and told him that R #24 was having difficulty breathing the day before on [DATE] and they had reported that to the nurse. He stated that once he heard of the outcome to R #24, he had both CNA's write a statement and give it to the CNE. This occurred on [DATE]. RN #5 stated that when he came back to work he was going to speak with the CNE but that never happened. He stated that he had not been asked what happened regarding R #24. RN #5 also said that when he came on shift that day [DATE] he did not recieve report that R #24 was having any issues. (continued on next page)

Printed: 06/30/2024
Form Approved OMB
No. 0938-0391

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	K. On [DATE] at 10:23 am during an interview with CNA #5 he stated that he reported that R #24 was having difficulty breathing to the nurse who was an agency nurse. She told him that she would make a note of it. CNA #5 stated that R #24 was wheezing a little bit and it was concerning. He stated that he didn't know R #24 very well because he had just moved onto that hall. He stated that he did write the statement and turned it into the CNE. He stated that he had not spoken to the CNE about it and doesn't know if the other CNA had either.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45426 Based on record review and interview, the facility failed to provide written discharge notification with required information to a resident's representatives or send a copy to the Ombudsman (long term care advocate for residents) of a discharge for 1 (R #1) of 3 (R #1, R #9, R #3) residents sampled for discharge. This deficient practice has the potential to cause the resident representatives and the Ombudsman the inability to make informed decisions about resident's care and not have access to an advocate who can inform them of their options and rights. The findings are: A. A record review of R #1's medical record face sheet revealed the following: 1. R #1 was admitted to the facility on [DATE] for rehabilitative occupational therapy (OT) and physical therapy (PT) after having a subdural hematoma craniotomy (an operation in which a small hole is made in the skull or a piece of bone from the skull is removed to show part of the brain to remove a blood clot from the exterior of the brain) after a fall at his home. 2. R#1 has the following diagnoses: encounter for surgical aftercare following surgery on the nervous system; traumatic subdural hemorrhage (a traumatic head injury, such as a blow to the head or a fall resulting in significant bleeding inside the skull, and rapidly building pressure against the brain) with loss of consciousness of unspecified duration subsequent encounter; unspecified intellectual disabilities (a condition characterized by significant limitations in both cognitive functioning and adaptive behavior that originates before the age of 22); age-related cognitive decline; Lennox-Gastaut Syndrome, not intractable with status Epilepticus (a severe and rare type of epilepsy with multiple different types of seizures and status epilepticus-when a seizure lasts too long or occur close together and the person doesn't recover between seizures, intractable-not easily managed or controlled with medication). This list is not all inclusive does not contain all of R #1's diagnoses. 3. R #1 has a healthcare representative (a person who has been named as the health care decision-maker for another person). 4. R #1 was discharged from the facility on 09/26/22 to (name of group home). B. On 11/02/22 at 11:40 am, during an interview with R #1's family member, she stated that she was R # 1's healthcare representative because R #1 has a developmental disability (a severe, chronic disability of an individual 5 years of age or older due to a mental or physical impairment or combination of mental and physical impairments, and results in substantial functional limitations in three or more of the following areas of major life activity; Self-care; Receptive and expressive language; Learning; Mobility; Self-direction; Capacity for independent living; and Economic self-sufficiency). She stated that R #1 functioned at the intellect of an 11- or [AGE] year-old and could not make rational decisions about his healthcare. She stated prior to R #1's discharge, she had not received any written notification or a Notice of Medicare Non-Coverage (NOMNC-a notice that indicates when care is set to end from a skilled nursing facility that includes information for how to appeal {a challenge to a previous determination or decision} the provider's decision to end services). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. On 11/02/22 at 11:39 am, during an interview, program manager of (name of group home agency) stated that prior to the R #1's discharge to his group home (a substitute home, usually located in a residential neighborhood, providing care for disabled persons, or others with special needs) from the facility on 09/26/22, the group home did not have written notification of R #1's discharge. The program manager stated she asked the facility if R #1's discharge from the facility could be delayed a day to review R #1's care requirements and to prepare for his return home. The program manager reported that R #1 had a developmental disability that made it necessary to coordinate his discharge from the facility back to his group home living. The group home was informed at the time of the group home's request that additional days would have to be paid out of pocket. R #1 was already being transported home by the facility. The group home had not received a copy of the NOMNC for R #1. D. On 11/02/22 at 10:10 am, during an interview, the business manager stated she had provided a written NOMNC to R #1 on 09/23/22 which he signed. She stated that she did not provide a written copy to his healthcare representative because when she asked R #1 if he wanted a copy sent to anyone else, he said no. She stated that she was not aware that he had a healthcare representative and that was not there before [the information for R #1's healthcare representative]. She also stated that she was not aware that R #1 had a diagnosis of an intellectual disability. The business manager stated that had she known that R #1 was intellectually disabled and had a healthcare representative she would have provided the healthcare representative with a written copy of the NOMNC. E. Record review of the NOMNC signed by R #1 revealed the information in the NOMNC was not provided to any other providers or representatives of R #1 by the facility. No name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman was provided with the NOMNC. No information of the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities was provided with the notification. F. On 11/14/22 at 2:03 pm, during an interview, with the Ombudsman, the Ombudsman stated she had not received a copy of the discharge notice for R #1. She stated that facilities are required to notify the Ombudsman's Office when residents are discharged .

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39822

Based on record review and interview, the facility failed to ensure that the care plan had been implemented and revised for 1(R #17) resident of 1(R #17) residents reviewed for up to date care plans by,

1. Not updating the care plan for falls after R #17 fell and suffered fractures.

2. Not updating a care plan to reflect new hip and pelvic fractures and interventions to address resident comfort related to those fractures.

These deficient practices are likely to result in staff not being aware of residents care needs, preferences, and residents not receiving the needed care. The findings are:

A. Record review of the face sheet revealed R #17 was admitted to the facility from a local hospital on 03/03/22 with a primary diagnosis of left femur [long bone in the upper leg that extends from the hip to the knee] fracture and a secondary diagnosis of dementia [a group of symptoms that affects memory, thinking and interferes with daily life] without behavioral disturbance [a pattern of disruptive behaviors].

B. Record review of census revealed R #17 was admitted to hospice [end of life care] services on 04/20/22.

C. On 11/03/22 at 11:20 am, during an interview with Registered Nurse (RN) #10 she revealed that R #17 fell on [DATE] and on 09/27/22 was found to have new fractures of the left hip and also of the pelvis [includes sacrum, hip bones and tailbone]. She revealed she thinks the resident was trying to get from her bed to her wheelchair at the time of the fall.

D. Record review of current care plan [labeled, Last Care Plan Review Completed 08/08/2022] for R #17 under, Focus revealed [first name of R #17] is at risk for falls: Impaired mobility initiated on 03/07/22. R #17's care plan also revealed will have no falls with injury by next review .Interventions, Provide resident with opportunities for choice. Bed in low position. Keep wheelchair out of site while in bed. Assist resident/caregiver to organize belongings for a clutter-free environment the resident room and consistent furniture arrangement. Encourage resident to attend activities that maximize their full potential while meeting their need to socialize. Implement the following safety precautions Frequent Monitoring, Call button and personal belongings with in reach.

There were no updates to the care plan following the fall that occurred on 09/23/22.

E. On 11/03/22 at 2:12 pm, during an interview with CNA (Certified Nurse Assistant) #15 she revealed, I was there [working on 09/23/22] but I was in the dining room [when R #17 fell]. They had her [R #17] on the wheelchair when I went back [to the unit] after [the meal] she [R #17] was complaining about pain and she was saying she hurt. CNA #15 confirmed that R #17 was not able to identify the location of the pain.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. Record review of nursing progress note dated 09/26/22 at 4:15 pm, revealed, the hospice nurse had visited and Concerns about hip pain especially left hip, combativeness with turning that started on Saturday [09/24/22] morning. G. Record review of R #17's care plan for comfort revealed the Focus was initiated on 03/07/22, [first name of R #17] exhibits or is at risk for alterations in comfort related to chronic pain, Osteoporosis, spinal stenosis [narrowing] and was not updated after her fall on 09/23/22 and the recognition of resultant bone fractures on 09/27/22. The only update for this focus was in the Goal which was revised on 08/08/22 with [first name of R #17] will not experience pain by the next review. There were no updated Interventions for this care plan Focus since 03/07/22. There were no interventions regarding ways to reposition resident to prevent pain and discomfort. There were no interventions regarding alternative pain relief measures related to fractures.

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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. 39822 Based on observation, record review and interview, the facility failed to ensure standards of practice were followed regarding use of side rails on the bed for 1 (R #17) of 1 (R #17) resident reviewed for having side rails utilized on her bed. This deficient practice could likely result in harm to any affected resident if they become entrapped [stuck between the bed rail and the mattress]. The findings are: A. Record review of the face sheet revealed R #17 was admitted to the facility from a local hospital on 03/03/22 with a primary diagnosis of, fracture of left femur [long bone in upper leg extending from the hip to the knee] and a secondary diagnosis of dementia [a group of symptoms that affects memory, thinking and interferes with daily life] without behavioral disturbance [a pattern of disruptive behaviors]. B. Record review of facility policy titled, NSG260 Bed Rails last revision 09/01/22 revealed in pertinent part, The Bed Rail Evaluation will be completed upon .change in bed or mattress . C. Record review of Electronic Health Record (EHR) for R #17 revealed, the most current Bed Rail Evaluation was completed on 08/20/22 and it directed, No bed rail(s) to be used. D. On 11/01/22 at 2:55 pm, during an interview with Certified Nursing Assistant (CNA) #11 she revealed R #17 sometimes has her side rails up but not all the time. E. On 11/01/22 at 3:20 pm, during an observation of R #17, she was lying in bed on her back with the head of the bed (HOB) elevated approximately 25 degrees. She was on an air mattress and there were half-sized side rails raised at the upper aspect of the bed.

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 11/04/2022
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview the facility failed to implement a timely discharge for 1 (R #9) of 3 (R #1, 9, and 21) residents reviewed for discharge planning by not discharging R #9, a short term, skilled (skilled services include physical therapy, occupational therapy and speech therapy) resident once she had finished her rehabilitation; and the facility kept the resident for long term care. This deficient practice could likely cause the resident to have a decline in her Activities of Daily Living (ADL's) ue to the resident no longer participating in therapy and could become depressed when she wasn't discharged back to her group home. The findings are: A. Record review of the face sheet for R #9 indicated that she was admitted on [DATE]. R #9 had been at the hospital recovering from Pneumonia (an infection of the air sacs in one or both the lungs. Characterized by severe cough with phlegm, fever, chills and difficulty in breathing). R #9 was sent to the facility for rehabilitation and improvement in her ADL's before returning to her group home. B. Record review of the care plan dated 04/21/22 indicated the following: In the FOCUS section of the care plan it indicated that R #9 has potential for discharge, or is expected to be discharged , related to: Admission for skilled short-term stay. C. Record review of the Post Admission Patient /Family Conference dated 04/23/22 indicated in the patient stay expectation was thatt R #9 was a short term stay resident and was home bound. D. Record review of the Physical Therapy Discharge Notes dated 05/13/22 indicated that the reason for discharge from PT (Physical Therapy) was that R #9 was discharging home. E. On 11/01/22 at 9:55 am during an interview with the group home Registered Nurse (RN) #10, he stated that R #9 was admitted to the facility after being hospitalized with Pneumonia. She (R #9) went there (SNF) to do some rehab before she could come back to her home. RN #10 stated that R #9 was supposed to do her rehab and then discharge home but that did not happen. He stated that the rehab ended and they just kept her. There was no communication and they would call and would never get a call back. He stated that multiple people from the group home called and they never got a hold of anyone who knew what was going on. When they did finally get a meeting there was just a bunch of finger pointing. Come to find out the Social Services person left and that was part of why they never got a call back. They (the group home) finally just said to discharge her, so they could get her home. R #9 discharged on [DATE]. (continued on next page)

Printed: 06/30/2024
Form Approved OMB
No. 0938-0391

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	325064	A. Building B. Wing	11/04/2022

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 11/01/22 at 3:08 pm during an interview with the past Director of Rehabilitation (DOR), she stated that somehow the wires were crossed with R #9. She stated that it was known that once she came off therapy she was supposed to go home, she wasn't sure what happened, but she knows that the group home was not notified that she (R #9) was discharged from therapy on 05/16/22. She remembers that the group home contacted the facility and asked them what was going on and the facility told them that she had been discharged from therapy. She stated that there wasn't any communication. She stated that it was known that after R #9 finished therapy she would be going home, so it isn't clear where the breakdown occurred. She stated that after therapy discharges a resident, Social Services handles discharges. G. On 11/02/22 at 12:21 pm, during an interview with the Group Home Case Manager #1, she stated that no one made her aware that R #9 was supposed to have been discharged . She stated that she didn't know that R #9 had been discharged from physical therapy. She stated that no one from the facility was calling her back to find out what was going on. She stated that the Social Workers at the facility kept changing, she felt like this was part of the breakdown that occurred. They requested a meeting and at that time requested R #9 to be discharged back to them. Resident was discharged on [DATE].

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39822

Based on record review and interview the facility failed to provide quality care for 1 (R #17) of 1 (R #17) resident reviewed by delaying in identifying a hip fracture [the upper part of the upper bone of the thigh that extends from hip to knee] and pelvis [a break of the bony structure of the pelvis {to include sacrum, hip bones and tailbone}] for 3 days following an unwitnessed fall and then not communicating with staff about the new fracture for consideration when transferring/repositioning the resident which likely resulted in unnecessary pain and further limiting R #17s range of motion. The findings are:

Findings R #17

A. Record review of the face sheet revealed R #17 was admitted to the facility from a local hospital on 03/03/22 with a primary diagnosis of left femur [long bone in upper leg that extends from the hip to the knee] fracture and a secondary diagnosis of dementia [a group of symptoms that affects memory, thinking and interferes with daily life] without behavioral disturbance [a pattern of disruptive behaviors].

B. Record review of census revealed R #17 was admitted to hospice [end of life care] services on 04/20/22

C. On 11/01/22 at 2:40 pm, during an interview with R #17's husband and Power of Attorney for Health Care [legal document that empowers a specific individual to make decisions on your behalf concerning your medical condition, treatment, and care] (HCPA) decisions, he revealed, on Saturday [09/24/22] he came to visit R #17 as he does each day. A hospice guy [Home Health Aide [HHA]] comes by and gives her a shower Saturday and touched her side [left] and it hurt. Then [on] Monday here comes the hospice guy [HHA] again to give her a shower and he [the hospice HHA] text me and says she is in a lot of pain and he called [first name of the hospice nurse who cares for R #17] and she [the hospice nurse] ordered an X-ray [test that produces images of the structures inside your body, particularly your bones] [On] Tuesday [09/27/22] [first name of hospice nurse for R #17] called and said she [R #17] had a fractured left hip and pelvis. He [R #17's husband] revealed he used to get her up in her wheelchair [prior to the fall on 09/23/22] when he came to see her, almost daily, she enjoyed being taken around the facility and talking to other residents, now she mostly just yells whenever you disturb [turn her in bed, bathe] her. He stated, She will never get out of bed again.

D. On 11/01/22 at 3:30 pm during an interview with the Certified Nursing Aide (CNA) #11 caring for R #17 she revealed, she cares for R #17 often and turns her in bed every two hours when she it there. She stated, she is turned just side to side like everyone. CNA #11 revealed, there have been no new instruction for how to turn R #17 since the new hip and pelvic fractures were diagnosed on [DATE].

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F 0684 Level of Harm - Actual harm Residents Affected - Few	E. On 11/01/22 at 4:30 pm, during an interview with R #17's hospice nurse, she revealed, she saw R #17 on 09/26/22, that she [R #17] had a dramatic change in status, tremendous pain and could not bear weight on her left leg as she had previously been able to do. She [the hospice RN] asked for X-rays [to be obtained] and when the results were given to her [on 09/27/22] they revealed R #17 had a left hip fracture and a pelvic fracture. She called the nurse at the facility [RN #10] and was told [by RN #10] that R #17 had been found on the floor by her bed around dinner time [4:30 pm] on Friday evening [09/23/22] they [facility staff] found her on the floor by her bed, they thought she had just tried to get into her wheelchair (w/c) by herself to go to dinner, she assessed her and thought she was fine [was not injured] so they put her in to her w/c and gave her dinner. The hosice RN revealed for R #17's comfort they would keep her in bed as moving her contributed to her pain. She confirmed she had not updated a plan of care to help alleviate R #17's pain related to fractures [with interventions such as specific ways to turn resident, ice or heat packs] but had spoken with R #17's husband to educate him about the need for more pain control with medication. F. On 11/03/22 at 10:30 am, during an interview with the Medical Director, she revealed that because R #17 is a hospice patient, the focus is on her comfort only. She reported that she would think that she [R #17] might not be comfortable lying on the left side. G. On 11/03/22 at 1:20 pm, during an interview with the Hospice Home Health Aide (HHA) he revealed that he was never given any instructions on how to move R #17 after her fall, but from his past work experience with trauma patients he knew how to handle turns so that the resident remains comfortable and the fracture does not become displaced [change the alignment of the fractured bone]. H. On 11/03/22 at 1:35 pm, during an interview with the Nurse Practitioner (NP) caring for R #17 she revealed On Saturday [09/24/22] they [staff at the facility] had told me she [R #17] was agitated (feeling or appearing troubled or nervous) the night before and they [the facility staff caring for R #17] were wondering if she needed more of, I think Ativan [medication for anxiety] and I think morphine [medication for pain] [the NP was not aware of the fractures at that time]. She confirmed that, after becoming aware of the hip fracture on she believes Tuesday [09/27/22] when called about R #17's X-ray report and notified of the hip fracture she had not written any new orders in terms of how to position the resident or other interventions [examples, ice or heat] to promote comfort. She revealed she had just learned of the pelvic fracture when she reviewed the X-ray report on this day [11/03/22]. I. On 11/03/22 at 2:12 pm, during an interview with CNA #15 she revealed, I was there [working on 09/23/22] but I was in the dining room [when R #17 fell]. They had her [R #17] on the wheelchair when I went back [to the unit] after [the meal] she [R #17] was complaining about pain and she was saying she hurt. CNA #15 confirmed that R #17 was not able to identify the location of the pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	J. On 11/03/22 at 11:20 am, during an interview with Registered Nurse (RN) #10 [nurse who was caring for R #17 when she fell on [DATE]] she revealed, I was working by myself [no other nurse or Certified Medication Aide (CMA) to assist her with medication passes] on the floor that day and I never had to work that floor alone before. I want to say that first, because that had a lot to do with it [not following up with an incident report and calling the physician and the POA after R #17's fall]. I was just passing medications, and it took forever because they [the residents] had all these needs whenever I went into the room. I don't remember if it was 4:00 or 4:30 [pm] when they [the Certified Nursing Assistants (CNA's)] called me to [first name of R #17] room and she was on the floor, the aides [CNA's] said they found her there. She was on the bare floor. She had those soft socks on, no not with the little pads [tread stop/anti slip pads to help prevent falls]. The wheelchair was there [by her bed where she fell] she might have been trying to move into it or from it. When I did my assessment, any place you touched her she was yelling and moving you couldn't touch anything, but she didn't say she hurt. I moved her arms and legs and there was no difference in her yelling. We got her up in the chair [w/c] and she settled [became more calm] I asked the CNA's [who had workedd with R #17 more often than the nurse had] and they said it was kind of normal behavior for her [R #17] she yelled and did not answer questions [as part of her usual behaviors]. I just got too busy and let it slip my mind [to report the incident]. No, I didn't call the husband or the doctor that day. I did the CIC [Change in Condition/Incident report] when I came back the following Tuesday [09/27/22] and that is when I notified the Nurse Practitioner and the husband. K. On 11/04/22 at 9:51 am, during an interview with RN (Registered Nurse) #12, the nurse who cared for R #17 on the weekend after fall [09/24/22 and 09/25/22] she reported I didn't really know her [R #17] [and didn't know she had new fractures] well, she was combative [ready or eager to fight] with the CNA's that Saturday morning and we couldn't get her changed for quite a while. At the time her husband came in around 8:00 [am], she was just confused and she was kicking and thrashing (moving in a violent way) about. She had difficulty moving out of the bed and yelled more when we did try to get her up.