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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40795 Based on observation and interview, the facility failed to provide a call light for 3 (R #60, R #97, and R #254) of 3 (R #60, R #97, and R #254) resident reviewed for accommodation of needs. This deficient practice could likely result in the resident not receiving attention or assistance when needed. Findings for R #254: A. Record review of the facility's policy titled Call Lights last revised 06/01/21, revealed that all residents will have a call light or alternative communication device within their reach at all times when unattended. Staff will respond to call lights and communication devices promptly. B. On 03/23/22 at 8:44 am, during an observation of R #254, the call light was observed to be rolled into a ball and pinned to the wall. C. On 04/07/22 at 10:59 am, during an interview with Licensed Practical Nurse #13, when asked if R #254 uses her call light, he explained She would always be yelling into the hall or pressing the call light. Usually because she had a lot of pain due to her hernia. Now she is here due to a UTI. The most recent time. When she was in the 100 hall, the call light was on the floor. After a while, we stated clipping it to her gown or sheets, or shirt. When asked if it is normally clipped to the wall, he explained, I have seen it like that. I don't know why it would be like that. I would ask the CNAs [Certified Nurse Assistant] and they would say 'I don't know' but there is no one else who could do that [clip it to the wall]. For example, I saw that there was one resident who would accidentally press the call light and she was bed bound so, somebody did it [clipped it to the wall] and I think its because they [CNAs] don't want to see the lights on. 45426 Findings for R #60 D. Record Review of R #60's medical record revealed R #60 was admitted to the facility on [DATE] with the following diagnoses: metabolic encephalopathy(damage to the brain due to serious impairment of body's metabolic [the chemical processes within the body required for life] activity); quadriplegia (paralysis of all four limbs), unspecified; weakness; muscle weakness (generalized); and other lack of coordination. These diagnoses are not comprehensive and do not include all of R #60's active diagnoses. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. On 03/22/22 at 3:11 PM, at approximately 5:30 PM, during an observation and interview, R #60 informed that his call light was out of his reach. He asked that it be adjusted to within his reach, which is in front of his mouth. To activate the call light, he must blow through it. The Breathcall (Brand name for call light for disabled residents which is used by blowing or puffing air through it) call light was observed to consist of a flexible metal neck and a disposable filter assembly (clear plastic disposable mouth piece resident blows into, to activate call light). The filter assembly was observed twisted to and pointing to the rear wall behind R #60's headboard out of R #60's reach. R #60 stated the call light was moved out of the way when CNAs had attended to him earlier. RN #1 confirmed the call light was out of his reach and re-positioned the call light so that it was in within his reach in front of his mouth. R #60 stated when his call light is not within his reach, he cannot ask his roommate for assistance because R #60 only speaks English and his roommate only speaks Spanish. An observation was made confirming R #60's roommate only spoke Spanish. F. On 3/24/22 at 1:00 PM, during an observation, the call light for R #60 was observed to be out of reach for R #60. It was twisted so that it faced the rear wall. R #60's roommate's family was visiting his roommate at the time and activated their father's call light to call for assistance for R #60. CNA #12 was observed feeding R #60 earlier. CNA #12 answered the roommate's call light, returned R #60's call light within reach, and left the room. Findings for R #97 G. On 03/28/22 at 5:08 PM, during an observation, R #97 was observed in his bed resting. His call light was observed on the floor, under his bed, out of his reach. H. On 3/28/22 at 5:12 pm, during an interview, CNA # 13, confirmed the light should be on the bed within R #97's reach and placed the call light on the bed within his reach. I. On 3/30/22 at 3:35 PM, R #97 was observed in his wheelchair, in the middle of his room, eating M&Ms and attempting to reach for M&Ms that had fallen to the ground. His call light was not observed to be within his reach. J. On 3/30/22 at 4:01 PM, during an interview, CNA #13 confirmed call lights should be within a resident's reach and placed R #97's call light with him in his wheelchair.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DD. On 3/24/22 at 1:19 PM, during an interview with family members for R #7, they stated the facility has been losing R #7's clothes. There are times when they come to visit him and he is only wearing a brief but no shirt and no pants. The facility has lost all his clothes in the past. They have replaced all his clothes and he has pants. The family had brought more pants for R #7 today. The family members stated R #7 wants to be dressed in his pants, at least, daily, and not just his brief. R #7 also stated he wanted to be dressed in his pants at least, daily. Both he and his family stated that it is okay if he goes shirtless but his preference is pants everyday. R #7 was coherent during this interview with his family present and his affect was bright compared to a previous observation when he was alone and incoherent. He had not been able to state during a previous interview why his pants were not on, and why he was wearing only a brief and a sweatshirt at that time.

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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 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 follow-up reports within 5 working days from the date of the incidents to the State Survey Agency for 5 (R #s 97, 212, 213, 214, and 215) of 5 (R #s 97, 212, 213, 214, and 215) 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. Record review of R #97 Complaint Narrative Investigation Report (5 day) revealed the incident happened on 12/06/21. There was no 5 day follow-up report completed or submitted to the State Survey Agency, and no request for an extension. B. Record review of R #212 Complaint Narrative Investigation Report (5 day) revealed the incident happened on 02/01/22. There was no 5 day follow-up report completed or submitted to the State Survey Agency, until it was brought to the Acting Center Executive Directors #1 and #2 attention. The five day follow-up occurred on 04/19/22. C. Record review of R #213 Complaint Narrative Investigation Report (5 day) revealed the incident happened on 11/29/21. There was a request for an extension which was granted and would be due on 12/07/21. There was no 5 day follow-up report completed or submitted to the State Survey Agency. D. Record review of R #214 Complaint Narrative Investigation Report (5 day) revealed the incident happened on 11/29/21. There was a request for an extension which was granted and would be due on 12/07/21. There was no 5 day follow-up report completed or submitted to the State Survey Agency. E. Record review of R #215 Complaint Narrative Investigation Report (5 day) revealed the incident happened on 11/29/21. There was a request for an extension which was granted and would be due on 12/07/21. There was no 5 day follow-up report completed or submitted to the State Survey Agency. F. On 04/07/22 at 2:20 pm, during an interview with Center Executive Director #1 and #2, they both agreed that for the five requested five day follow ups, they can't find when they were completed and sent to the state reporting agency.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40795 Based on record review and interview, the facility failed to maintain a process that would include all residents when scheduling care plan meetings for 6 (R #'s 29, 31, 35, 44, 85, and 96) of 6 (R #'s 29, 31, 35, 44, 85, and 96) residents reviewed for the occurance of care plan meetings. This deficient practice could likely result in residents not given the opportunity to participate in a person-centered care plan development. The findings are: A. Record review of the facility's policy titled Person-Centered Care Plan, last revised 07/01/19, revealed A comprehensive, individualized care plan will be developed within 7 days after completion of the comprehensive assessment [a Minimum Data Set assessment of a resident's overall health which is required to be evaluated every three months] for each patient that includes measurable objectives and timestables to meet a patient's medical, nursing, nutrition, and metal and psychosocial needs that are identifed in the comprehensive assessments 7. Care plans will be: 7.1 Communicated to appropriate staff, patient, resident representative(s), family; 7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals; and 7.3 Documented on the care plan evaluation note. 9. The Center has the responsibility to assist patients to participate by: 9.1 Extending invitations to patient and resident representative(s) sent in advance; 9.2 Holding care planning meetings at the time of day when the patient is functioning best; 9.3 Facilitating the inclusion of the patient/resident repetitive(s) to attend; and 9.4 Incorporating the patient's personal and cultural preferences in developing goals of care. Further review reveals, 10. Care plan meetings will be documented by use of the Care Plan Meeting note. Findings for R #96 B. On 03/23/22 at 12:19 pm, during a interview with the family member of R #96, when asked if she was invited to and attends care plan meetings, she replied, I cant remember when was the last time I had a phone call about the care plan meetings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review of the most recent MDS (Minimum Data Set, a comprehensive assessment of the resident and their functional capabilities) revealed that assessments occurred on the following dates: 10/29/21 and 03/02/22. D. Record review of Care Plan Meeting note revealed that the last documented care plan meeting was 09/16/21. Findings for R #31 E. On 03/24/22 at 9:34 am, during an interview with the family member of R #31, when asked if she was invited to and attends care plan meetings, she replied We haven't had one this year. The last time was before Christmas. F. Record review of the most recent MDS revealed that assessments occurred on the following dates: 07/22/21, 10/19/21, and 01/17/22. G. Record review of Care Plan Meeting note revealed that the last documented care plan meeting was 08/19/21. Findings for R #85: H. On 03/22/22 at pm, during an interview with R #85, when asked if she was invited to and attends care plan meetings, she replied, I've never heard of that. I. Record review of the most recent MDS revealed that assessments occurred on the following dates: 11/26/21 and 02/25/22. J. Record review of Care Plan Meeting note revealed that the last documented care plan meeting was 09/30/21 and 04/22/21. Findings for R #29 K. On 03/23/22 at 9:44 am, during an interview with R #29, when asked if she was invited to and attends care plan meetings, she replied I don't receive invitations or go to them. L. Record review of the most recent MDS revealed that a quarterly assessment occurred on 01/12/22. M. Record review of Care Plan Meeting note revealed that no care plan meetings were documented for R #29. Findings for R #44: N. On 03/22/22 at 3:27 pm, during an interview with R #44, when asked if he was invited to and attends care plan meetings, he replied, I don't get invitations or attend. O. Record review of the most recent MDS revealed that assessments occurred on the following dates: (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/26/21, 10/26/21, and 01/25/22. P. Record review of Care Plan Meeting note revealed that the last documented care plan meeting was 08/19/21. Findings for R #35: Q. On 03/23/22 at 10:00 am, during an interview with R #35, when asked if she was invited to and attends care plan meetings, she replied I went once and I left because I felt like they didn't listen to me. R. Record review of the most recent MDS revealed that assessments occurred on the following dates: 07/15/21, 10/20/21, and 01/20/22. S. Record review of Care Plan Meeting note revealed that the last documented care plan meetings were: 05/13/21, 08/05/21, 10/28/21. T. On 03/29/22 at 10:54 am, during an interview with the Social Services Director (SSD), when asked how the care plan meetings are scheduled, he stated We schedule care plan meetings every week. [For long-term care residents] the case manager from their [residents'] insurance will send us a calendar of when they need to do them. We rely on the case manager of the insurance to send us a calendar for the month. For the skilled residents, we call the family and talk about meetings for the resident. We set them up depending on their availability. We have the skilled care plan meeting every week, depending on their availability. When asked how invitations are given to the residents, he replied, My assistant will write a letter and she will give it to the resident. If its Thursday, they [the residents] will usually refuse because they want to play BINGO. Most long-term care residents prefer to have meetings after 12. In the mornings, they usually have dialysis or activities. We have talked to the Activities Director about changing the BINGO days. U. On 03/29/22 at 11:47 am, during an interview with the Social Services Assistant (SSA), when asked to explain her process for setting up care plan meetings, she explained that when she first started she would receive a calendar from the MDS nurse and the calendar would have all the residents who needed a care plan meeting for that month. She would then schedule the care plan meetings for every Thursday, and invite the care coordinator, the Activities Director, head of nursing, therapy, and the families, two weeks in advance. When asked if invitations were extended to the resident or families, she explained I type up a letter for the families and resident. I mail the copies to the families and I keep a copy for myself. When asked if the calendars are still in use, she replied Lately, I haven't been getting those calendars from the MDS because we don't have an MDS nurse. I have since been reaching out to the care coordinator to determine who needs a care plan meeting. I should keep a list of who needs a meeting and when. It's not flowing as it should. When asked how long there has been a MDS nurse vacancy, she replied two months. When asked if residents participate in care plan meetings, she replied, Some residents do attend. With my experience, they are in bed and they need help getting out of bed and getting ready. I will talk to them, the day before to remind them. I will go about fifteen minutes before to remind them and sometimes they will refuse or sometimes they are playing BINGO. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. On 04/01/22 at 9:35 am, during an interview with the SSD, when asked if the care plan meetings for R #96 was over due, he confirmed, Her last one was in September [of 2021] and her next one should have been in December [of 2021]. when asked if the care plan meetings for R#'s 31, 85, 29, 44, and 53 were over due, he confirmed, yes. When asked what type of training he received for setting up care plan meetings, he replied, We got two days of training. Our old Social Services Director trained us on how to do notes, enter care conference, UDAs [assessments], and MDS entries. She showed us the contacts for the case mangers and how to set up the care conferences. We rely on the case managers calendars. We used to get calendars form MDS but she left in about February [of 2022] and nobody said how to follow the MDS schedule. The didn't say that we should follow the MDS calendar.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 40795 Based on observation, interview, and record review, the facility failed to: 1. maintain a safe medication administration process for 4 (R #23, 35, 54 and 86) of 4 (R #23, 35, and 86) residents reviewed for medication ingestion, 2. label enterally (involving or passing through the intestine, either naturally via the mouth and esophagus, or through an artificial opening) administered nutrition for 1 (R #54) of 1 (R #54) resident assessed for labeled enteral formula (a closed, ready-to-hang enteral container pre-filled with sterile, liquid nutritional formula by the manufacturer and considered ready-to-administer). This deficient practice could likely result in serious injury as: 1. Residents or staff members have the opportunity to freely open the medication cart or 2. Residents may or may not ingest medication that was or was not prescribed to them. 3. Residents may not get adequate amount of nutrition or nutrition may not be safe to administer due to being left out too long. The findings are: A. Record review of the facility's policy titled Medication Administration: General, last revised 06/01/21, revealed that staff should 1. Maintain security of cart and keys at all times. Further review revealed 8. Administer medication. 8.1 Assist patient as needed. 8.2 Remain with patient until administration is complete. Do not leave medications at the patient's bedside. B. On 03/22/22 at 9:40 am, during an observation of the medication cart, it was noted that the medication cart was left unlocked and unattended. C. On 03/22/22 at 9:42 am, during an interview with LPN (Licensed Practical Nurse) #2, when asked if the medication cart was left unattended and unlocked, LPN #2 stated, I forgot to lock it (the med cart). I came back here to lock it. I was being careless. Findings for R #35 D. On 03/22/22 at 10:04 am, during an observation of R #35, it was noted that R #35 was sitting in her bed shifting items on her night stand, including a small cup of medications. E. On 03/22/22 at 10:04 am, during an interview with R #35, when asked if the cup contained medications, R #35 stated, I have my medication here on my night stand. They left it here at 4 am. It's my thyroid medication. They couldn't wake me up so they just leave it here. I'm a heavy sleeper. I have to take it at 4 am because it has to be 4 hours before a meal or 4 hours after. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of physician orders, dated 01/27/22, revealed that R #35 receives Levothyroxine Sodium Tablet. Give 50 mcg [micrograms] by mouth one time a day for low thyroid hormone. Further review of physician orders revealed that R #35 does not have an order allowing her to administer her own medications. Findings fro R #86 G. On 03/24/22 at 10:40 am, during an observation of the resident's room, multiple pills were found on the floor around R #86's bed and also in the vent of the heating and cooling unit installed in the wall. H. On 03/24/22 at 10:45 am, during an interview with LPN #13, when asked to compare the pills to the Medication Administration Report (MAR) for R #86, LPN #13 was able to confirm that 3 of the found pills were atorvastatin (a medication used to treat cholesterol) and Vitamin D. He then explained the MAR says she accepted it [at every opportunity] except for on 03/21/22 at 7:00 pm by the med tech. I. On 03/25/22 at 11:50 am, during an observation of the resident room, one additional red pill was found on the floor. J. On 03/25/22 at 11:55 am, during an interview with LPN #13, when asked to identify the pill, LPN #13 stated, it seems like it may be a iron pill. When asked if residents are allowed to ingest medications without supervision, he confirmed, no. When asked if it was ok for medications to be left unattended in the resident's room, he confirmed, no. When asked if nursing staff should watch the resident to ensure that the medications were ingested, he confirmed, yes. 45426 Findings for R #23 K. On 4/07/22 at 1:26 PM, during an observation and interview, a small pink pill was observed on R #23's bedroom floor, near his trashcan. LPN #3 observed the pill and stated it looked like a baby aspirin. She reported she gave R #23 his medicine that morning and he took them. When asked what the normal protocol for pills missed she stated she would document it .like a doctor . but she does not normally find medications on the floor and was unsure. She looked at R #23's MAR and R #23 does take baby aspirin. L. On 04/07/22 at 1:34 PM, during an interview, RN (Registered Nurse) #1 stated, the protocol for missed or unknown medicines was to identify the pill, replace it and then dispose of it. In addition, the incident should be documented (the resident, the location, identify what pill it was) and inform the provider. RN #1 stated continuing education was needed for the nursing staff. Findings for R #54 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. On 03/23/22 at 3:42 PM, during an observation, R #54 was observed to be on a closed, ready to hang enteral feeding system (a type of feeding where nutritional formula flows out from a feeding bag and into a feeding tube by the force of gravity pulling the formula in a downward direction directly into the digestive tract). The bag containing the enteral formula was observed to be missing a date and time. N. On 03/23/22 at approximately 4:45 PM, RN #2 came into the room to change out the bag of formula. When asked if the bag should be labeled, he dated the new bag with the resident's name, date, time and his initials. O. Record review of the facility's policy for Enteral Feeding: Administration by Pump dated 06/01/96 revision date: 06/01/21 states the following: 18. Set up feeding system 18.1.2 Fill in the information on the container's label (patient's name, room number, date, start time, and flow rate). 18.1.3 Label the administration set with start date and time. 28. Change formula container and administration set. 28.1.1 Each container of formula may hang no longer than 48 hours. 28.1.2 Change administration set with each new container of formula. P. According to a special report by the Journal of Parenteral and Enteral Nutrition titled Enteral Nutrition Practice Recommendations Volume 33 Number 2, March/April 2009 122-167, (C) 2009 American Society for Parenteral and Enteral Nutrition on page 129, To avoid misinterpretation, a label should be affixed to all EN (enteral) formula administration containers (bags, bottles, syringes used in syringe pumps). The label should reflect the four elements of the order form and therefore contain the following: patient demographics, formula type, enteral access delivery site/access, administration method, individuals responsible for preparing and hanging the formula, and time and date formula is prepared and hung. Page 141 states, 18. Closed-system EN formulas can hang 24-48 hours per manufacturer's guidelines. Q. On 3/24/22 at 8:58 AM, during an observation, no label was observed on R #54's formula bag. It appeared to have been peeled off.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45426 Based on record review and interview, the facility failed to provide ADL (Activities of Daily Living) assistance with oral care for 6 (R #15, 54, 59, 60, 70 and #157) of 6 (R #15, 54, 59, 60, 70 and #157) residents reviewed for ADL's. This deficient practices could likely affect the dignity and cause a decline in the overall physical health of the residents. The findings are: Findings for R #60: A. Record Review of R #60's medical record revealed R #60 was admitted to the facility on [DATE] with the following diagnoses: metabolic encephalopathy (damage to the brain due to serious impairment of body's metabolic [the chemical processes within the body required for life] activity); quadriplegia (paralysis of all four limbs) unspecified; chronic gingivitis (a bacterial infection which causes inflammation of gums around the base of teeth), plaque (a sticky deposit on teeth) induced; weakness; muscle weakness (generalized); and other lack of coordination. These diagnoses are not comprehensive and do not include all of R #60's active diagnoses. B. On 3/22/22 at 2:46 PM, during an observation and interview, R #60 was observed to have his natural teeth, but they were observed to be in poor condition. When asked if the staff assist him with daily brushing of his teeth, he said they did not brush his teeth daily. He stated he wanted his teeth brushed every day, but he must ask the Certified Nursing Assistants (CNAs) each day/shift in order to receive his oral care. If he does not ask, his teeth will go unbrushed. No CNAs have prompted or initiated brushing his teeth. No oral care products (toothbrushes, toothpaste, dental floss) were observed in R #60's belongings in his bedside drawer. C. Record Review of Activities of Daily Living (ADL) Task list for R #60 revealed for the month of March 2022, 12 instances of oral care being documented and being provided by staff on 12 different days for R #60. Those dates were: 03/01/22, 03/06/22, 03/07/22, 03/08/22, 03/13/22, 03/14/22, 03/16/22, 03/17/22, 03/18/22, 03/20/22, 03/22/22 and 03/23/22. There are 31 calendar days in the month of March. D. Record review of summary of dental services provided onsite at the facility to R #60 by TruCare Mobile (a mobile dental care service provider) on 05/17/21 revealed Patient's Oral hygiene was: Non-Existent. R #60 was admitted to the facility on [DATE] and has remained under the facility's constant care. The summary also revealed Dental calculus (a form of hardened dental plaque) level (amount) was generalized: Heavy . Next recommended dental cleaning appointment: 3-4 months because of: Inadequate oral hygiene home care. PPDs (pocket probing depths- the depth of the periodontal pocket which is the space between the teeth and the surrounding gums and bone when using a probe) exceeding health limits (greater than 3 mm [millimeters]) The summary stated that R #60 is a high caries (decay and crumbling of a tooth or bone) risk due to dentin (middle layer of the tooth between the enamel and the pulp) exposures, current carious lesions (tooth decay on the tooth crown or root), xerostomia (abnormal dryness of the mouth due to insufficient secretions, dry mouth). The dental provider's recommendations for daily oral health care: Soft tooth 2 x (times) daily, Interproximal (the space between adjacent teeth) flossing daily, Regular fluoride toothpaste. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Record Review of R #60's most recent Care Plan dated 08/21/21, indicated R #60 .requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting . and the intervention by the facility was to .Provide (resident) with total assist of 1 for personal hygiene (grooming). Findings for R #15 F. Record Review of R #15's medical record revealed R #15 was admitted to the facility on [DATE] with the following diagnoses: hemiplegia, unspecified affecting unspecified side (a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body), unspecified lack of coordination, and muscle weakness (generalized). R #15 a resident who is enterally fed {method of providing nutrients directly into the gastrointestinal (GI) tract (digestive tract) when a person cannot receive food orally}. R #15 is also a resident who does not get anything by mouth. These diagnoses are not comprehensive and do not include all of R #15's active diagnoses. G. Record review of R #15's Kardex as {a brand name for the record of all ADL care provided for each shift in LTC (long term care) facility} and care plan as of 03/29/22, revealed oral hygiene/mouth care should be performed each shift and as needed. H. On 03/23/22 at 3:26 PM during an interview and observation, POA (Power of Attorney) #1 vehemently (in a forceful, passionate, or intense manner) stated that the facility was not brushing R #15's teeth. POA #1 opened R #15's mouth to show that there was significant plaque and tarter buildup. Approximately 3 millimeters of buildup was visible along R #15's gumline and teeth. POA #1 stated if he were not here and did not brush or wipe R #15's teeth, it would never get done. R #15 is non-verbal and when R #15 was asked if his teeth were getting brushed, he shook his head no. R #15 was unable to recall the last time his teeth were brushed. R #15 informed his teeth had not been brushed today. I. Record review of Record Review of Activities of Daily Living (ADL) Task list for R #15 revealed for the month of March 2022 12 documented instances of oral care being provided by staff on 12 different days. One day of oral care being provided by the resident on 03/16/22 was documented. The dates of oral care provided by staff in March 2022 were 03/06/22, 03/07/22, 03/08/22, 03/10/22, 03/13/22, 03/14/22, 03/17/22, 03/18/22, 03/20/22, 03/22/22, 03/23/22, and 04/03/22. Findings for R #70 J. 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. K. Record review of R #70's care plan, revealed the following: Resident is at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: Limited mobility RT (related to) MS (Multiple Schlerosis) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goals: [Resident] will improve current level of function in: bathing, grooming/personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) by next review as evidenced by improved ADL scores. Interventions: [Resident] needs a mechanical lift for transfers. and encourage resident/patient to pace him/herself during ADL activity. L. On 04/26/22 at 3:38 pm during an interview, R #70 reported she has dentures and can do her own oral care. However, if the CNAs do not get her out of bed, she is unable to clean her dentures or her mouth. There are many days when there are not enough CNAs to get her out of bed, so she has been unable to clean her dentures. She just leaves the dentures in. R #70 stated she required 2 people to assist her out of bed. She must ask the CNAs to get her dentures or ask them to bring her denture cleaning supplies to her. R #70 stated CNAs will not bring her or assist with oral care without her requesting it. M. Record review of Record Review of Activities of Daily Living (ADL) Task list for R #70 revealed for the past 30 days there were 7 documented instances of R #70 providing her own oral care. The dates were 03/29/22, 04/8/22, 04/10/22, 04/11/22, 04/13/22, 04/17/22, and 04/18/22. Findings for R #157 N. Record Review of R #157's medical record revealed R #157 was admitted to the facility 03/18/22 with the following diagnoses: multiple sclerosis; and unspecified symptoms and signs involving cognitive functions and awareness. These diagnoses are not comprehensive and do not include all of R #157's active diagnoses. O. On 4/07/22 at 4:20 PM, during an interview, R #157 reported the only time his teeth were brushed was when he got a shower, no other times. R #157 stated he did not know he could get his teeth brushed every day and stated he was unsure as to what he was entitled to. He reported he would brush his teeth every day and is able to if the staff were to bring him his oral hygiene supplies, such as a basin, bottle of water/rinse cup, his toothbrush and toothpaste. The staff do not provide him with opportunities to care for his teeth each day. He demonstrated that he still had full upper body strength and coordination, but stated he could not get out of bed on his own to use the bathroom or the bathroom sink. R #157 stated he did not know if staff would or could bring him his oral care supplies. He was unsure if this was allowed. P. Record review of R #157's care plan and Kardex (part of the electronic medical record that CNA's look at to assist in providing care) revealed the following: resident was to be encouraged to brush his teeth and gums twice daily, provide oral hygiene mouth care twice a day and as needed, and use a mouth rinse as appropriate. R #157 requires assistance for ADL care in grooming, bathing personal hygiene, etc. Q. Record review of Record Review of Activities of Daily Living (ADL) Task list for R #157 revealed for the past 30 days there were 10 documented instances on 10 separate days of R #157 providing his own oral care. The dates were 04/03/22, 04/06/22, 04/07/22, 04/10/22, 04/12/22, 04/13/22, 04/14/22, 04/18/22, 04/19/22, and 04/21/22. Findings for R #54 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Y. Record Review of Activities of Daily Living (ADL) Task list for R #59 revealed for the past 30 days there were 12 documented instances on separate days of staff providing oral care for R #59. The dates were 03/06/22, 03/07/22, 03/08/22, 03/10/22, 03/13/22, 03/14/22, 03/16/22, 03/17/22, 03/18/22, 03/20/22, 03/22/22, and 03/23/22. Z. On 3/31/22 at 2:28 PM, during an interview, LPN #8 stated CNAs are responsible for completing oral care. Nurses document oral care in the residents' chart. She stated she does not observe directly but will just sign it off in the oral care section of the Treatment Administration Record (TAR) for gum treatment/care because CNAs do not always inform the nurses if a resident has received oral care. If oral care is not listed on the resident's chart it will not be documented by a nurse. AA. On 04/01/22 at 11:32 AM, during an interview, CNA #5, stated it was not possible to get to brushing all the residents' ADLs (brushing teeth, nail care, shower, shaving, etc.) in a shift with only 2 CNAs a shift. If there is time, they will try to get them all done but there are many times when only 1 CNA is working the floor. Teeth and grooming are supposed to be done every day but are usually only done when the resident gets a shower. She was only aware of one resident who refuses ADLs. BB. On 04/04/22 at 4:20 pm, during an interview, CNA #11 reported he had only done 3 residents' teeth this shift, R #59, R #54, and R #15. The residents' teeth are done during showers. The shift ends at 6:00 pm. He and NA (Nursing Assistant) #1 have 26 residents they are caring for this shift. NA #1 reported she had only been working 3 days at the facility, but she had not done any oral care for the residents. She reported as a NA student, NA's are taught that oral care is done twice a day for residents.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview, the facility failed to admnister antibiotic medication as ordered, ensure resident attended follow up Outpatient Parenteral Antibiotic Therapy ([NAME]) appointment and monitor for signs and symptoms of infections for 1 (R #45) of 3 (R #s 45, 79, 96) residents reviewed for wound care/pressure ulcers. This deficient practice likely resulted in R #45's below the knee amputation to become infected, leading to R #45 being readmitted to the hospital. The findings are: Resident #45 A. Record review of R #45's Face Sheet indicated that he was admitted on [DATE] with a below the knee amputation. B. Record review of the transfering hospital record revealed R #45 was admitted to the hospital on 12/31/21 and In the General Admission Inpatient note written by (name of physician) indicated the following: .(R #45) was recently discharged to a rehab facility on 1/27 after being treated for an necrotizing soft tissue (a serious bacterial infection that results in the death of the body's soft tissue can cause blisters, skin discoloration, fever and infection) of the right foot status post right below the knee amputation (BKA) on 12/31. Patient (R #45) was initially treated with vancomycin and then switched to cefazolin 2 g (grams) every 8 hours with plan for end of therapy on 2/16 . Patient was sent to the emergency department (ED) after being seen in the (infectious disease) ID clinic. CT (cat scan) lower extremity obtained reported concerns of abscess as well as osteomyelitis (infection in the bone) at the stump site. R #45 was discharged [DATE] with orders for Antibiotic Regimen: Cefazolin 2g (grams) q8h (every 8 hours) Start Date of Antibiotics: 01/20/22 and Projected End Date of Antibiotics: 02/16/22. C. Record review of the facility physician orders from 01/26/22 admission indicated that R #45 MAR (Medication Administration Record) February 2022 indicated that following: Cefazolin Sodium Chloride Solution 2-0.9. Use 100 ml (Milliliter) intravenously one time a day for IV (intravenous) ATB (antibiotic) therapy until 02/16/22. Infuse 30 minutes. This order was discontinued on 02/04/22. D. Record review of the facility physician orders dated 02/04/22 indicated that a new order was placed for Cefazolin in Sodium Chloride Solution 2-0.9 GM/100ML-% Use 100 ml intravenously every 8 hours for IV ATB therapy until 03/04/22. Infuse 30 minutes. E. On 04/05/22 approximately 3:30 pm, during an interview with the Unit Manager, she confirmed that R #45's IV medication that he was receiving, when he arrived at the facility was not the right dose and the facility was only giving it once per day until the order was changed on 02/04/22. F. Record review of the medical chart indicated that R #45 had an appointment with Infectious Disease clinic appointment on 02/11/22 at 9 am. R #45 did not make it to this appointment. There was no indication or reason given in the record why appointment was missed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. Record review of the medical chart indicated that R #45 had an appointment at the [NAME] clinic on 02/17/22. R #45 did go to this appointment, instead he was admitted to the hospital from that appointment with concerns of purulent discharge (liquid or discharge that oozes from a wound) from his stump. Patient was sent to the ED (Emergency Department)and a CT lower extremity obtained reported concerns of abscess as well as osteomyelitis 9 bone infection at the stump site. H. Record review of the hospital medical records dated 02/23/22 Addendum Status:Completed (name of resident/R #45) was seen, examined and discussed with (name of physician) today. Pt (patient/R #45) is admitted for BKA stump abscess with concern for osteomyelitis after he had BKA 12/31/21 due to necrotizing fasciitis. He was sent to a SNF to receive IV cefazolin to complete infection treatment, but was readmitted since cefazolin was underdosed at the skilled nursing facility and pt had breakthrough infection. I. On 03/23/22 at 12:43 pm, during an interview with R #45, he stated that he had a below the knee amputation (BKA) of his right leg and while he was in the facility it became infected and he was readmitted to the hospital on 02/17/22. J. On 04/05/22 approximately 3:30 pm, during an interview with the Unit Manager, she confirmed that R #45 missed one of his appointments.The Unit Manger also stated that R #45 was not very complaint with his wound when he got here. He wouldn't keep the bandage in place. He would take off the bandage but refuse to let anyone see it. The facility was only supposed to be monitoring for signs and symptoms but were unable to do that. She stated that someone had made an attempt to call the surgeon but wasn't sure who. There was no documentation around a staff member reaching out to surgeon to inform him of what some of the barriers were with R #45 or the Physician. K. On 04/06/22 at 10:36 am, during an interview with RN (Registered Nurse) #1, she stated that R #45 refused to let the facility see his BKA (stump). They weren't supposed to do anything with it but to make sure it looked ok and was healing. It was being treated in the outpatient clinic. He would not allow them to even unwrap it to see how it was healing. However, he would take the bandage off and would leave it uncovered. They wouldn't know he would do it because he would pull his pants over it. She knew he did it and when she would ask to see it, he wouldn't let her. RN #1 was not aware of any staff member reaching out to the physician or to the surgeon to discuss what was going on with R #45 or any issues they may be having with monitoring the wound. L. On 04/01/22 at 9:19 am, during an interview with NP (Nurse Practitioner) #1, she stated that she wasn't aware that R #45 would not allow anyone at the facility to see his wound. She stated that she knows the BKA was being treated at the clinic but was unaware that he wouldn't allow nursing staff to look at his wound to monitor for infection.

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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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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40795 Based on record review and interview, the facility failed to ensure restorative services were available for 8 (R #3, R #20, R #60, R #61, R #64, R #85, R #33 and R #254) of 8 (R #3, R #20, R #60, R #61, R #64, R #85, R #33 and R #254) residents reviewed for mobility capabilities. This deficient practice could likely result in resident joints feeling contracted (when muscles, tendons, joints, or other tissues tighten or shorten causing a deformity) or weakened. The findings are: Findings R #85 A. On 03/22/22 at 2:10 pm, during an interview with R #85, she stated They used to come massage my hands and rotate my feet. I asked them to come do it again. The last time they did it was about two and a half weeks ago I asked for it but I don't know why I can't have it. B. Record review of physician notes, dated 02/25/22, revealed that R #85 was requesting restorative therapy services as she is no longer in therapy but would like to continue to perform movements. C. Record review of the Electronic Health Record (EHR) revealed that R #85 was prompted to receive restorative therapy. Findings for R #254: D. Record review of the face sheet revealed that R #254 was admitted to the facility on [DATE] with the following pertinent diagnosis: restless legs syndrome, and chronic pain syndrome. E. Record review of the care plan, dated 12/16/21, revealed that R #254 is at risk for decreased ability to perform ADL(s) [Activities of Daily Living such as hygenic measures, walking, and toileting] in bathing, grooming, personal hygiene, dressing, eating, bed, mobility, transfer, locomotion, toileting) related to: Limited mobility, NWB [Non Weight Bearing] RLE [Right Lower Extremities]. 45426 F. Record review of the restorative binder for the restorative program revealed the following: A restorative referral dated 01/25/22 for R #3 with one documented refusal on 01/07/22 due to diarrhea and one documented restorative session on 01/28/22. A restorative referral dated 01/31/22 for R #64 with no documented restorative sessions. A restorative referral dated 01/25/22 for R #20 with three documented restorative sessions, 01/27/22, 01/28/22, and 01/29/22. A restorative referral dated 02/01/22 for R # 61 with no documented restorative sessions. A restorative referral dated 02/01/22 for R #33 with no documented restorative sessions. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A restorative referral dated 02/02/22 for R #254 with no documented restorative sessions. Findings R #60 G. On 03/30/22 at 2:05 PM, during an interview, R #60 reported he had been going to therapy but then it had stopped. He would like to have restorative therapy. H. On 03/31/22 at 3:25 pm, during an interview, the Director of Rehabilitation (RHP) stated his department provided a referral for R #60 to the restorative program for range of motion on 02/07/22. He stated he did not know why R #60 had not been getting restorative therapy. He does not keep any copies of restorative referrals for those residents who have completed physical or occupational therapy who are recommended/referred to restorative therapy. He was unable to produce a copy of R #60's restorative program. A copy of R # 60's restorative referral was not found in the restorative binder. RHP stated he was not aware that residents at the facility had not been receiving restorative therapy. According to RHP, restorative referrals from his department were continuing to be made for residents. He was not aware of any barriers or obstacles for residents receiving restorative therapy. He has been giving referrals to RN #1 and CNA #1. They accepted the referrals. He does not know who is supervising the restorative services program. I. Record review of R #60's Physical Therapy Discharge Summary for dates of service 01/02/22-02/07/22 indicated the following: Discharge Recommendations: Recommended services upon discharge include: Restorative Nursing/Maintenance Program. J. Record review of R #60's Occupational Therapy Discharge Summary for dates of service 00/22 indicated the following: Discharge Recommendations: Home Exercise Program, Physical Therapy Plan and Compensatory Strategies. Current Status: Discharge Diagnosis: Muscle weakness; Discharge Setting: = Long term care setting; Prognosis to Maintain CLOF (Current Level of Function)=Good with consistent staff follow-through. K. On 04/01/22 at 11:32 AM, during an interview CNA # 5 stated she was not sure who was overseeing her department, the restorative department since, (name of nurse) has left. She reported that RN #1 just tells her which residents to weigh. CNA #5 also stated that RN #1, RHB and OT were aware that she had not been providing restorative to residents and ask her what she is doing daily. She has not done any restorative services since 01/29/22. L. On 04/01/22 at 12:46 PM, during an interview, RN#1 stated in the past she has input items for restorative on the ADL (Activities of Daily Living) task list so they show up in the Kardex. She no longer does that. Approximately in September of last year was the was the last time she put items in the task list. She has not been putting in restorative programs into the Kardex. She does not know who is currently supervising the Restorative program. Findings R #64 M. On 04/07/22 at 12:34 PM, during an interview, R #64 stated she wanted to continue therapy and needed to practice walking. She wants to know how to start restorative. She reported she was in therapy before and would like to continue. She has bad knees. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings R #3 N. On 04/07/22 at 12:58 PM, during an interview, R #3 reported she wants to continue restorative therapy. She stated they used to come and get her. There used to be a girl who would do exercises in bed, but they stopped doing that. Findings R #61 O. On 04/07/22 at 1:48 PM, during an interview, R #61 stated he was getting therapy and then it stopped. He would like to continue with therapy and is interested in restorative therapy. Findings R #20 P. On 4/07/22 at 2:05 PM, R #20 stated she has not received restorative therapy. She had therapy before but then it stopped. She was supposed to be getting restorative therapy, but the CNA who had been providing it is on the floor now because there are not enough workers. Q. On 04/07/22 at 2:30 pm, during an interview with Certified Nursing Assistant (CNA) #5, when asked what types of restorative services she offers, she explained, I am considered a Restorative CNA . I first started working Restorative in mid January. I started working at this facility in October [2021] as a CNA. What I actually do is, I weigh people weekly and monthly. I have only done restorative services three times. Therapy went ahead and referred a few residents to me and they tell me what kind of exercises to do, what transfers, and what the goal is for them. When asked who she has worked with, she explained, I worked with [Name of R #254] three times. The last time I worked with her was January 29th [2022]. The last time I did anything at all [related to restorative services] was January 29th [2022]. When asked if notes of her restorative sessions were available she replied, I wasn't able to chart in the computer, but that is how I would chart [if she could]. When asked if she worked with R #85, she explained, She is on the list to receive restorative. One day I was supposed to train with another CNA. I only got to do restorative exercises for 3 days. I started [restorative] on the 27th [of January 2022]. My restorative services ended on the 29th [of January 2022]. They only had me do assistive feeding in the dinning room. They [the facility] are so short staffed that CNA work has taken over restorative. Residents ask me [for restorative services] almost on a daily basis and I feel awful because I don't have an answer for them. [Name of R #254], she tells me that she is forgetting how to walk. I had a talk with her and she started doing better. Before she went to the hospital she told me she felt like she was forgetting how to walk. When [name of other resident] was alive, his hands were very weak but I saw an improvement with him. Even though it was a short amount of time, it really helps. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R. On 04/07/22 at 3:26 pm, during an interview with RN (Register Nurse) when asked what the restorative aids are currently doing, she explained that they are responsible for weighing the residents and due to staffing, they also work as regular floor CNAs. When asked how the restorative program is currently functioning, she explained that the restorative CNA's are being used to work as regular CNA's due to staffing shortages and so their primary goal under restorative services is now to weigh the residents. When asked how the restorative program should look, RN #1 stated, Initially, they [therapy] would give me papers [with restorative suggestions] and I would put them into the tasks list and then the restorative CNA would see it and they would have a 30 day goal. If they [the residents] were still doing it for 30 days, then I would review it and then they could always be added back on or reevaluated. I just got a 30 second training on it. I did that for about 3-4 months. For a while, we didn't have a restorative aid so, it was a consistent not working out situation. When asked if R #85 and R #254 would benefit from restorative services, she confirmed, yes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40795 Based on observation, record review, and interview, the facility failed to change out the oxygen tubing and humidifier for 11 (R #'s 3, 29, 31, 42, 59, 63, 72, 77, 88, 89, and 99) of 11 (R #'s 3, 29, 31, 42, 59, 63, 72, 77, 88, 89, and 99) residents reviewed for oxygen use. This deficient practice could likely result in: 1. Residents developing a bacterial or viral infection, if the oxygen tubing was not changed and/or documented as changed on a weekly basis or as otherwise ordered and; 2. Not providing humidified oxygen to a resident may result in discomfort in the nasal passage or throat due to a lack of moisture that naturally occurs when breathing through the nose and mouth. 3. Residents receiving supplemental oxygen without physician orders. The findings are: A. Record review of the facility's policy titled Oxygen: Nasal Cannula, last revised 06/01/21, revealed that staff should: 1. Verify order. [physicians order] 2. Determine appropriate oxygen source and need for humidification . 3. Gather supplies: . 3.2 Nasal cannula labeled with date of initial set-up . 10. If humidifier is used: 10.1 Label with date; 10.2 Attach humidifier directly to the oxygen outlet source; 10.3 Test pop-off valve located on top of humidifier . 16. Replace disposable set-up every seven days . Findings for R #72: B. On 03/22/22 at 3:55 pm, during an observation of the oxygen tubing for R #72, it was observed that the oxygen tubing was not dated. C. Record review of the Electronic Health Record (EHR) revealed that R #72 was admitted on [DATE] with the pertinent diagnosis of chronic obstructive pulmonary disease, unspecified (a lung diseases that block airflow and make it difficult to breath). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Record review of physician orders revealed that R #72 did not have an order for supplemental oxygen. Findings for R #88: E. On 03/22/22 at 4:08 pm, during an observation of R #88's oxygen tubing, it was observed that the oxygen tubing was not dated F. Record review of the EHR revealed that R #88 was admitted on [DATE] with the following pertinent diagnosis of obstructive sleep apnea (a breathing disorder that causes you to repeatedly stop and start breathing while you sleep). G. Record review of physician orders revealed that R #88 did not have an order for supplemental oxygen. Findings for R #29: H. On 03/23/22 at 9:45 am, during an observation of the oxygen tubing for R #29, it was observed that the oxygen tubing was not dated and the humidifier was empty and not dated. I. Record review of the EHR revealed that R #29 was admitted on [DATE] with the pertinent diagnosis of acute respiratory failure with hypoxia (An absence of enough oxygen in the tissues to sustain bodily functions) and chronic obstructive pulmonary disease, unspecified. J. Record review of physician orders, dated 10/10/21, instruct staff for an Oxygen tubing change weekly Label each component with date and initials. Every night shift every Sun [Sunday] Label each component with date and initials. Physician orders dated, 10/06/21, instruct staff to Clean external filter on oxygen concentrator every night shift every 7 day(s) and as needed for O2 [oxygen] therapy Physician orders, dated 10/11/21, instruct staff to provide there resident with Oxygen at 1-6 L/min [liters of oxygen flowing per minute] via Nasal Cannula to keep O2 sats [saturation] greater than 89% as needed Findings for R #42: K. On 03/23/22 at 9:52 am, during an observation of the oxygen tubing for R #42 it was observed that the tubing was not dated. L. Record review of the (EHR) revealed that R #42 was admitted on [DATE] with the following pertinent diagnosis: unspecified acute lower respiratory infection and chronic obstructive pulmonary disease, unspecified. M. Record review of physician orders revealed that R #42 did not have an order for supplemental oxygen. Findings for R #31: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	N. On 03/23/22 at 10:08 am, during an observation of the oxygen tubing for R #31, it was observed that the tubing was not dated. Further observation of the resident's humidifier revealed that it was dated 02/08/22. O. Record review of the Electronic Health Record (EHR) revealed that R #31 was admitted on [DATE] with the following pertinent diagnosis dependence on supplemental oxygen. P. Record review of physician orders revealed the following: Physician orders, dated 01/24/21, instruct staff to Clean filter on oxygen concentrator weekly every day shift every Sun [Sunday] Physician orders, dated 01/24/21, instruct staff to Oxygen tubing change weekly Label each component with date and initials. Every day shift every Sun [Sunday] Label each component with date and initials Physician orders, dated 03/03/21, instruct staff to Oxygen at 1-5 L/min via Nasal Cannula continuously to maintain sats above 90%. As needed, for as needed for oxygen under 88% Findings for R #3: Q. On 03/23/22 at 10:54 am, during an observation of the oxygen tubing for R #3, it was observed that the tubing was not dated. Further observation revealed that the humidifier was dated 03/19. R. Record review of physician orders, dated 12/01/21, revealed an order for Oxygen at 1-6L/min via Nasal Cannula continuously to keep O2 [oxygen] sats [saturation] greater than 89%. Every day shift and every night shift. Further record review revealed an order, dated 12/05/21, for Oxygen tubing change weekly Label each component with date and initials. Every day shift every Sun [Sunday] Label each component with date and initials. Findings for R #89: S. On 03/23/22 at 2:29 pm, during an observation of R# 89's humidifier, it was observed to be empty and dated 3/5. Further observation of R #89's oxygen tubing revealed that the tubing was not dated. T. Record review of EHR revealed that R #89 was admitted on [DATE] with the following pertinent diagnosis: acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia (the increase in partial pressure of carbon dioxide), obstructive sleep apnea (adult) (pediatric) pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and the right side of the heart) due to lung diseases and hypoxia. U. Record review of physician orders, dated 03/07/21, instructed staff to provide Oxygen at 1-6 L/min via Nasal Cannula continuously to keep O2 [oxygen] sats [saturation] greater than 89%, every day shift and every night shift. Further review revealed a physician order, dated 03/07/21, instructed staff to provide Oxygen tubing change weekly. Label each component with date and initials. Every day shift every Sun [Sunday] Label each component with date and initials 45426 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings R #59 V. On 03/29/22, at 3:02 PM during an observation, R #59 was observed in his bed on oxygen and being fed enterally (Enteral feeding is a method of supplying nutrients directly into a person's gastrointestinal tract). No labeling or date was observed on the nasal cannula tubing or on the water cannister on the oxygen concentrator (a type of medical device used for delivering oxygen to individuals with breathing-related disorders, by taking air from the room, compressing it and filtering the purified oxygen from it before delivering to the patient). W. Record review of the Medication Administration Record (MAR) Treatment Administration Record (TAR) for March 2022 revealed the following orders R #59: Oxygen at 1-6 L/min via Nasal Cannula to keep O2 sats (amount of oxygen traveling through your body with your red blood cells) greater than 89% every day shift -Start Date- 04/28/2021 0600 (6:00 am) Oxygen at 1-6 L/min via Nasal Cannula to keep O2 sats greater than 89% every night shift -Start Date- 04/27/2021 1800 (6:00 pm) Oxygen tubing change weekly. Label each component with date and initials. every day shift every Sunday related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA (deficiency in the amount of oxygen reaching the tissues) (J96.01) Label each component with date and initials -Start Date- 04/25/2021 0600 (6:00 am) Clean filter on oxygen concentrator weekly every day shift every Sunday Findings R #63 X. On 03/23/22 at 9:31 AM, during an observation , R #63 was observed to be receiving oxygen while lying in bed in his room. No date or label was observed on his nasal cannula tubing on the water cannister of the oxygen condenser. Findings R #99 Y. On 03/23/22 at 3:47 PM, during an observation, R #99 was observed on portable oxygen. No date or label was observed on the nasal cannula tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings R #77 Z. On 03/23/22 at 5:16 PM, during an observation, R #77 was observed to be on oxygen in bed in her room. No date or label was observed on the nasal cannula tubing or on the water cannister of the oxygen condenser. AA. On 03/25/22 at 10:57 am, during an interview with the Unit Manager, when asked how often the oxygen tubing should be changed out, she stated Tubing should be changed every Sunday When asked how someone would be aware if the tubing was changed, she replied, There should be a date on the tube and the humidifier bottle When asked how often the humidifier gets changed out, she replied When it gets about a quarter way down we change out the humidifier When asked to review the the oxygen tubing for R #29, she confirmed that the oxygen tubing should have a date, the humidifier should be changed, and that the tubing shouldn't be on the floor BB. On 04/04/22 at 3:45 pm, during an interview with Certified Nursing Assistant (CNA) #7, when asked who changes out the oxygen tubing and humidifier, she replied We usually do, the CNAs change them on Sundays. Sometimes, the nurse will replace the water bottles or cannula CC. On 04/05/22 at 10:33 am, during an interview with Med Tech #1, when asked if the oxygen tubing and humidifier get changed every Sunday, she explained It doesn't happen every Sunday. Our shift [day shift] comes in and we change them. A lot of the tasks that we give the night shift, they don't get it done. There is a break in communication about what doesn't get done and they don't tell us, like the oxygen tubing. They always have excuses about being short staffed. The nurses are here at night and they need to make sure they are doing their rounds. If the nurse doesn't say 'hey did you do it', they won't care. If the night nurses would check, then the day shift wouldn't have to do double work. DD. On 04/06/22 at 11:13 am, during an interview with Registered Nurse (RN) #1, when asked to explain the process to ensure that the oxygen tubing and humidifiers are being changed, she stated The CNAs will round and the nurses should ensure that it is being changed. When asked to explain how residents who do not have orders for oxygen receive oxygen, she explained, They should get an order. If the resident has hypoxia then they need to call the doctor. When asked why R #'s 72, 88, and 42 receive oxygen without orders she replied It's a standing order, the nurses should put the order in and notify the provider and the family.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 40795 Based on interview and record review, the facility failed to ensure physician visits were occurring every 60 days for 3 (R #'s 54, 59, and 65) of 3 (R #'s 54, 59, and 65) residents reviewed for physician visits. This deficient practice could likely result in residents not receiving medical attention as required. The findings are: A. Record review of the facility's policy titled Physician Services, last revised 08/31/20, revealed: 1. The Center Executive Director (CED) will establish a process for tracking licensed practitioner visits according to the Standards and Procedures for all Licensed Independent Practitioners as well as state and federal regulations. 2. The CED will identify designee(s) to track and manage practitioner visits utilizing the PointClickCare (PCC) [software utilized for Electronic Health Record] Managing Physician Visits Reference Guide. 2.1 Designee(s) will enter practitioner visits into PCC at a minimum of weekly. 3. The CED will review the Physician Visits Report form PCC weekly to identify any passed due visits. B. Record review of physician notes revealed that the last physician's visit for R #54 occurred on 09/15/21. C. Record review of physician notes revealed that the last physician's visit for R #59 occurred on 09/17/21. D. Record review of physician notes revealed that the last physician's visit for R #65 occurred on 10/20/21. E. On 04/07/22 at 8:29 am, during an interview with Physician #1, she explained that there was a change in her office personnel and she has recently noticed that some long-term care residents were missing exam notes. When asked if R #54 was seen after 09/15/21, she explained [Name of practitioner] was supposed to see him in October [2021] but that appointment got canceled and I am not sure why. There was another appointment canceled on December 22 [2021]. That is one that should have been seen but was not. When asked if R # 59 was seen after 09/17/21, she explained, He was a resident that was canceled also. When asked if R #65 was seen after 10/20/21, she explained that she was seen on 02/23/22. When asked if there is a process to ensure that the residents are seen every 60 days, she explained that there were multiple employees who transitioned out of her office at the same time. She then explained On the first of the month of every month, my office manager puts all the long-term care patients on a list then the mid level physician will schedule them. I had an emergency meeting on the 31 [of March] and I saw that there were some residents who had not been seen.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40795 Based on interview, the facility failed to ensure that enough staff were available to provide wound care, ADL (Activities of Daily Living) care, and restorative services for all 111 residents listed on the facility census provided by the administrator on 03/21/22. This deficient practice could likely result in resident wounds not being assessed on a weekly basis, resident's oral hygiene not regularly maintained, resident showers not being completed, and residents not being able to get the assistance needed to get out of bed. The findings are: Findings related to wound care: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A. On 03/31/22 at 9:45 am, during an interview related to pressure wounds, Licensed Practical Nurse (LPN) #13 explained I usually work the 200 hall but because of how short staffed we are, I have been working on the 100 hall and when I get back to the 200 hall, the wounds will not have been 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 [residents who are not alert and oriented], its hard to follow-up to know if its getting worse. We all work 5-12 hour shifts. We brought this up with administration. Its hard to provide necessary care He went on to explain that staff feel like the care they deliver is done so in a desultory manner. He then stated In the 200 hall, we are very close and when I'm unable to provide the care, its upsetting. I have to handle 60 or more residents. Last Friday, there was only 3 nurses and a unit manager had to help on the floor. We had 2 Certified Nurses Assistants (CNAs) for each hall, except on the 400 hall, there was only 1 for a few hours. We try to do priorities first; shower, feeders [residents who are unable to feed themselves], the feeders remain in their rooms and they get fed 1 at a time. Whoever is last feeder gets cold food. Quality of care is affected by staffing shortages. Showers, those who can wait will shower later in the day. People who need pants [to be clothed on the lower half of their body], they probably wont get help to get up [out of bed] until about 10 [am] or 11[am]. People who need to be hoyered [assisted with a mechanical device that moves patients from one surface to another] into their power chair don't get put in the chair until later. There has been times when there is one CNA and the nurses have to work the floor. So med pass gets pushed back about an hour or two. If a nurse is handling a hall and a half, for example, the 100 hall and the 200 hall, if they have medications that need to be timely, some people will get medications on time and then I will have to go back around to give medications to the other residents later and it will throw you off. When staffing puts a lot of pressure on you, you don't want to leave CNAs alone. For ADL's [Activities of Daily Living], the CNAs should be doing all care and some nurses trust in them a lot. For others, you may have to verify, for example, if they are performing oral care. We have to prioritize things when we are short staffed. Most of the time we have two CNAs but we need three or more because four of them [residents] need hoyers, two [residents] are immoble, one [resident] is hospice, and half of the hall are blood sugars and obesity so they need help a lot of the time on the 200 hall. The 300 hall is more easy as they are more independent. The 400 hall, its pretty heavy, mostly gentlemen, there are four feeders, and one G-tube [a gastronomy tube is a surgical device that allows medical staff to administer liquid protein and calories directly into the stomach]. On the 100 hall there's five IV's [Intravenous, a method of inserting medication directly into a person's veins] at night. Each hall needs at least two CNAs and three to know that care is given properly. You have to take into account, breaks and lunches. We have two med techs [certified medication technicians]. We have a total of six CNAs who will be testing and transitioning to med techs. Right now, one works at the end of the week and the other at the beginning. We're supposed to have two nurses on the 100 hall to properly give care, five total nurses. Today we only have four nurses. The med tech is prioritized to the 100 hall. If we have three nurses, we split the halls and put the med tech on the split hall. B. 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. C. On 04/06/22 at 11:29 am, during an interview with RN (Registered Nurse) #1, 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. (continued on next page)

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Skies Healthcare & Rehabilitation Center	9150 McMahon Boulevard NW Albuquerque, NM 87114

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Findings related to restorative services: D. On 04/07/22 at 2:30 pm, during an interview with CNA #5, when asked what types of restorative services she offers, she explained, I am considered a Restorative CNA . I first started working Restorative in mid January. I started working at this facility in October [2021]. What I actually do is, I weigh people weekly and monthly. I have only done restorative services three times. Therapy went ahead and referred a few residents to me and they tell me what kind of exercises to do, what transfers, and what the goal is for them. When asked who she has worked with, she explained, I worked with [Name of R #254] three times. The last time I worked with her was January 29th [2022]. The last time I did anything at all [related to restorative services] was January 29th [2022]. When asked if notes of her restorative sessions were available she replied, I wasn't able to chart in the computer, but that is how I would chart [if she did]. When asked if she worked with R #85, she explained, She is on the list to receive restorative. One day I was supposed to train with another CNA. I only got to do restorative exercises for 3 days. I started [restorative] on the 27th [of January 2022]. My restorative services ended on the 29th [of January 2022]. They only had me do assistive feeding in the dining room. They [the facility] are so short staffed that CNA work has taken over restorative. Residents ask me [for restorative services] almost on a daily basis and I feel awful because I don't have an answer for them. [Name of R #254], she tells me that she is forgetting how to walk. I had a talk with her and she started doing better. Before she went to the hospital she told me she felt like she was forgetting how to walk. When [name of other resident] was alive, his hands were very weak but I saw an improvement with him. Even though it was a short amount of time, it really helps. E. On 04/07/22 at 3:26 pm, during an interview with RN #1, when asked what the restorative aids are currently doing, she explained that they are responsible for weighing the residents but due to staffing, they also work as regular floor CNAs. When asked how the restorative program should look, RN #1 stated, They [therapy] would give me papers [with restorative suggestions] and I would put them into the tasks list and then the restorative CNA would see it and they would have a 30 day goal. If they [the residents] were still doing it for 30 days, then I would review it and then they could always be added back on or reevaluated. I just got a 30 second training on it. I did that for about 3-4 months. For a while, we didn't have a restorative aid so, it was a consistent not working out situation. Findings related to oral hygiene: F. On 3/31/22 at 2:28 PM, during an interview, Licensed Practical Nurse (LPN) #8 stated CNAs are responsible completing oral care. Nurses document oral care in the residents' chart. She stated she does not observe directly but will just sign it off in the oral care section of the Treatment Administration Record (TAR) for gum treatment/care because CNAs do not always inform the nurses if a resident has received oral care. If oral care is not listed on the resident's chart it will not be documented by a nurse. G. On 04/01/22 at 11:32 AM, during an interview, CNA #5, stated it was not possible to get to brushing all the residents' ADL's (brushing teeth, nail care, shower, shaving, etc.) in a shift with only 2 CNAs a shift. If there is time, they will try to get the all done but there are many times when only 1 CNA is working the floor. Teeth and grooming are supposed to be done every day but are usually only done when the resident gets a shower. She was only aware of one resident who refuses ADL's. Findings related to showers and getting out of bed: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	H. 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. I. 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. J. 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. K. On 03/23/22 at 11:41 am, during an observation of R #33, she was observed to still be in bed. L. On 03/23/22 at 3:12 pm, during an interview with R #33 she stated that she got up around lunchtime. M. 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. N. 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. O. 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. P. 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. Q. On 04/04/22 at 5:03 pm, during an interview with CNA #9, when asked to explain how the staffing level effects her position, CNA #9 explained We don't have the opportunity to chart as we should. We don't have time to spend with patients. Some [residents] are very needy and need extra care, for example; sitting with them and talking with them. I am in and out. I don't have time to spend with those kind of patients. It takes me longer to go from one patient to another. Sometimes there are special needs like transfers . I try to get them showered but sometimes I don't get to them until after lunch. I try to do as much as I can. Some days that doesn't happen because I am literally going from one call light to another call light. People soil their beds due to diarrhea or bed wetting. I work very hard to get things done. The staffing moral suffers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R. On 04/05/22 at 10:59 am, during an interview with LPN #3 and Med Tech #1 to explain how the staffing level effects their positions, LPN #3 and Med Tech #1 explained, There's hardly any scheduled night shift nurses. They are not on the schedule. Someone from day shift will stay late or someone form management will work night. We don't have enough hired night shift nurses. We cant find agency. S. On 04/05/22 at 3:37 pm, during an interview with the Staffing Coordinator, he explained that a lot of the night shift nurses left at the beginning of the year and a number of staff left the facility when leadership changed. He then explained that Our goal is for us to have one RN [Registered Nurse] or LPN, two CNAs per hall, and a Med Tech on three halls. We staff four nurses in the day but the goal is to have five in the day, four nurses at night, and two CNAs per hall all the time. When asked to explain how the amount of staff scheduled for the day is determined, he explained that he calculates the PPD (numerical method of determining the amount of staff needed for each resident) and the goal is to have enough staff to reach a PPD of 3.0 everyday. T. Record review of the PPD revealed the following: For the month of December 2021, there were 11 days with a PPD below 3.0 and 1 day where the PPD was below 2.5. For the month of January 2022, there were 3 days with a PPD below 3.0. For the month of February 2022, there were 5 days with a PPD below 3.0. For the month of March 2022, there were 15 days with a PPD below 3.0 and 3 days where the PPD was below 2.5.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 20412 Based on observation, interview and record review, the facility's contracted pharmacy failed to ensure: 1. That R #6, received her Lyrica (used to treat pain caused by nerve damage, and prevention of seizures [having involuntary movement]), and not have to wait for nine (9) days, due to the unavailability of the medication in the facility; 2. That R #16's, medication administration labels on the blister-packs for Eliquis (a blood thinner), Gabapentin (used to treat pain caused by nerve damage) and Acetaminophen (used to treat minor aches and pain) were clear and understandable as to the administration of the medications, and 3. That R #22's, medication administration label on the blister-pack for Warfarin (Coumadin, a blood thinner that is monitored) contained two different dosages of the same medication, which was confusing to the nursing staff. Two different dosages of the same medication, should be in two separate blister-packs. These deficient practices could likely result in the resident's either not receiving their medications as prescribed, or receiving the wrong dosages of the medication. These deficient practices could likely result in affecting all 111 resident's listed on the facility's Resident Census obtained from the Center Executive Director on 03/21/22. Findings for R #6: A. On 03/24/22 at 6:53 pm, during an observation of the evening medication administration, LPN (Licensed Practical Nurse) #2 was noted to prepare the evening medications for R #6. LPN #2 stated that she would not be administering R #6's Lyrica medication to her as scheduled, as the medication was not available. B. Record review of R #6's physician orders dated 09/09/19, indicated an order for Lyrica 50 mg (milligram). Give 1 capsule by mouth two times a day for neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). C. Record review of R #6's March 2022, Medication Administration Record (MAR) indicated that R #6 did not receive her Lyrica medication on the following dates: 03/18/22, 03/19/22, 03/20/22, 03/21/22, 03/22/22, 03/23/22, 03/24/22, 03/25/22 and 03/26/22, which was a total of nine (9) days or eighteen (18) doses of the medication that were not received, dispensed, or administered to R #6, due to unavailability of the medication in the facility. D. Record review of web site, www.WebMD.com/Lyrica, revealed the following: .Use this medication regularly to get the most benefit from it .This drug works best when the amount of medicine in your body is kept at a constant level .Do not stop taking this medication suddenly . Findings for R #16: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 03/24/22 at 7:30 pm, during an observation of the medication administration, LPN #2 administered Eliquis 5 mg, Gabapentin 100 mg and Acetaminophen to R #16. F. Record review of the R #16's medication reconciliation review, noted the physician orders indicated for following: 1. Eliquis 5 mg give 2 tablets by mouth BID (twice a day) for 7 days and give 1 tablet by mouth BID, twice a day. The order is unclear as to when the 7 days the medication was to be administered. 2. Physician order dated 11/23/21, Gabapentin 100 mg 1 capsule by mouth in the morning, 2 capsules by mouth 1 time a day and 1 capsule by mouth 1 time a day. The order is unclear, needing clarification from physician. 3. Physician order dated 03/11/22, Acetaminophen 325 mg, 2 tablets every 6 hours (scheduled doses) and an order for Acetaminophen 325 mg, 2 tablets every 4 hours as necessary. The order for Acetaminophen was a duplication of the medication. Findings for R #22: G. On 03/24/22 (Thursday) at 7:05 pm, during an observation of the medication administration, LPN #2 administered Warfarin 5 mg to R #22. H. On 03/24/22 at 7:05 pm, during an interview, R #22 told LPN #2, that she administered the wrong dose of Warfarin to him. R #22 stated that he should have received the 5 mg of the Warfarin dose, instead she administered a 2.5 mg dose of the medication to him. I. On 03/24/22 at 7:20 pm, during an interview, LPN #2 reviewed the Warfarin blister-pack for R #22, and found out that the blister-pack contained Warfarin 2.5 mg and 5 mg doses in the same blister-pack. LPN #2 discovered that the 2.5 mg dose of Warfarin for Wednesday, had not been administered the day before as prescribed. LPN #2 confirmed that the Warfarin medication should have been dispensed into two separate blister-packs for the two different dosages instead of one blister-pack. J. Record review of the physician order dated 03/08/22, indicated Warfarin 5 mg one time per day every Tuesday, Thursday, Friday, Saturday and Sunday. Give 1/2 a tablet (2.5 mg) on every Monday and Wednesday for atrial fibrillation (an irregular heart beat).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 20412 Based on observation, record review, and interviews, the facility failed to ensure the medication error rate did not exceed 5% by performing 3 medication errors out of 27 opportunities for 2 (R #6 and 22) of 9 (R #6, R #9, R #14, R #16, R #22, R #36, R #95, R #164 and R #173) resident's reviewed during the medication administration. This resulted in a medication error rate of 11%. The findings are: Findings for R #22: A. On 03/24/22 at 7:05 pm, during an observation of the medication administration, LPN (Licensed Practical Nurse) #2 was noted to administer R #22's medications, which included Liquid Protein 30 ml (milliliter) by mouth twice a day, Gabapentin (a medication that can treat seizures [involuntary movements] and nerve pain) 100 mg (milligram) 1 capsule by mouth one time a day, Warfarin 5 mg by mouth 1 time a day every Tuesday, Thursday, Friday, Saturday and Sunday, and Furosemide 40 mg 1 tablet by mouth twice a day. B. On 03/24/22 at 7:05 pm, during an interview, R #22 told LPN #2, that she administered the wrong dose of Warfarin to him. R #22 stated that he should have received the 5 mg of the Warfarin dose, instead she had administered a 2.5 mg dose of the medication to him. C. On 03/24/22 at 7:20 pm, during an interview, LPN #2 reviewed the Warfarin blister-pack for R #22, and found out that the blister-pack contained Warfarin 2.5 mg and 5 mg doses in the same blister-pack. LPN #2 discovered that the 2.5 mg dose of Warfarin for Wednesday, had not been administered. LPN #2 confirmed that the Warfarin medication with two different doses for different days should have been dispensed into one blister-pack. The Warfarin medication should have been dispensed into two blister-packs for R #22. D. Record review of the physician order dated 03/08/22, indicated Warfarin 5 mg one time per day, every Tuesday, Thursday, Friday, Saturday and Sunday. Give 1/2 a tablet (2.5 mg) every Monday and Wednesday for atrial fibrillation (an irregular heart beat). E. On 03/24/22 at 7:30 pm, during an interview, after the administration, with LPN #2, when asked if she thought administering the Furosemide to R #22 at 7 o'clock in the evening was rather a late dose for him, instead of the administering the second dose of Furosemide at an earlier time, she stated that she did not realize that the medication could result in making the resident urinate all night. She stated that she was not familiar with the resident's that she was administering their medications to, that it was one her first times doing so. F. Record review of medicalnewstoday.com revealed the following: Furosemide is a strong diuretic (water pill) that helps the body get rid of excess water. It does this by increasing the amount of urine your body makes .Furosemide causes you to urinate more, so you should avoid taking it at bedtime . Findings for R #6: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 03/24/22 at 6:53 pm, during an observation of the evening medication administration, LPN #2 was noted to prepare the evening medications for R #6. LPN #2 stated that she would not be administering R #6's Lyrica (for pain) medication to her as scheduled, as the medication was not available. H. Record review of R #6's physician orders dated 09/09/19, indicated an order for Lyrica 50 mg, Give 1 capsule by mouth two times a day for neuropathy (weakness, numbness, and pain from nerve damage usually in the hands and feet). I. Record review of R #6's March 2022, Medication Administration Record (MAR) indicated that R #6 did not receive her Lyrica medication starting on 03/18/22, 03/19/22, 03/20/22, 03/21/22, 03/22/22, 03/23/22, 03/24/22, 03/25/22 and 03/26/22 , which was a total of nine (9) days or 18 doses of the medication that were not received, dispensed, or administered to R #6 due to unavailability of the medication in the facility. J. Record review of www.WebMD.com/Lyrica, revealed the following: .Use this medication regularly to get the most benefit from it .This drug works best when the amount of medicine in your body is kept at a constant level .Do not stop taking this medication suddenly .

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review, interview, and observation the facility failed to ensure that residents were free from significant medication errors for 2 (R #45 and #210) of 13 (R #6, #9, #14, #16, #22, #36, #45, #95, #164, #166, #173, #205, and #210) residents reviewed for medications. This deficient practice likely resulted in R #210 recieveing medications that were not prescribed to her likely contributing to her death and R #45 not receiving the IV (intravenous) antibiotic as prescribed likely worsening an infection. The findings are: Findings for R #45: A. Record review of R #45's Face Sheet indicated that he was admitted on [DATE] with a below the knee amputation. B. Record review of the trasnfering hospital records revealed that R #45 was admitted to the hospital on 12/31/21 and In the General Admission Inpatient note written by (name of physician) indicated the following: . (R #45) was recently discharged to a rehab facility on 1/27 after being treated for an necrotizing soft tissue (a serious bacterial infection that results in the death of the body's soft tissue can cause blisters, skin discoloration, fever and infection) of the right foot status post right below the knee amputation (BKA) on 12/31. Patient (R #45) was initially treated with vancomycin and then switched to cefazolin 2 g (grams) every 8 hours with plan for end of therapy on 2/16 . Patient was sent to the emergency department (ED) after being seen in the (infectious disease) ID clinic. CT (cat scan) lower extremity obtained reported concerns of abscess as well as osteomyelitis (infection in the bone) at the stump site. R #45 was discharged with orders for an Antibiotic Regimen: Cefazolin 2g (grams) q8h (every 8 hours) Start Date of Antibiotics: 01/20/22 and Projected End Date of Antibiotics: 02/16/22. C. Record review of the R #45's MAR (Medication Administration Record) for February 2022, indicated that following: Cefazolin Sodium Chloride Solution Use 100 ml IV (intravenously) one time a day for IV ATB (antibiotic) therapy until 02/16/22. Infuse 30 minutes. This order was discontinued on 02/04/22. D. Record review of the facility physician orders indicated that a new order was placed on 02/04/22 for Cefazolin in Sodium Chloride Solution 2-0.9 GM/100 ML-% Use 100 ml intravenously every 8 hours for IV ATB therapy until 03/04/22. Infuse 30 minutes. This new order reflected the order from the hospital. E. Record review of the medical chart indicated that R #45 had an appointment at the Outpatient Parenteral Antibiotic Therapy ([NAME]) clinic on 02/17/22. R #45 did go to this appointment. He was admitted to the hospital from that appointment with concerns of purulent discharge (a thick, milky white discharge indicating an unhealthy wound or infection) from his stump. Patient was sent to the ED (Emergency Department)and a CT lower extremity obtained reported concerns of abscess (a swollen area within body tissue, containing an accumulation of puss) as well as osteomyelitis at the stump site. (continued on next page)

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	F. Record review of the hospital medical records dated 02/23/22: R #45 was admitted with concerns of BKA stump abscess concerning for Osteomyelitis. He was sent to a SNF(Skilled Nursing Facility) to receive IV cefazolin to complete infection treatment, but was readmitted since cefazolin was underdosed at the skilled nursing facility and pt had breakthrough infection. G. On 03/23/22 at 12:43 pm, during an interview, R #45 stated that he had a below the knee amputation (BKA) of his right leg and that while he was here in the facility it became infected and he had to be readmitted to the hospital. H. On 04/05/22 approximately 3:30 pm, during an interview, the Unit Manager confirmed that R #45's IV medication that he was receiving when he arrived was not the right dose and the facility was only giving it once per day. Findings for R #210: I. Record review of the facility five day follow up report dated 01/10/22 indicated 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. J. 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 CNE), Family notified. Will continue to monitor. There was no evidence that the Physician was contacted regarding the medication error. K. Record review of the medications that were administered to R #210 included: Oxycodone (used to treat moderate to severe pain) 10 mg (milligram), Tramadol (used to treat moderate to severe pain) 50 mg and Hydroxyzine (used to treat anxiety, nausea and vomiting, skin rash, allergies, and itching of the skin) 25 mg Famotidine (used to treat stomach ulcers, conditions with too much stomach acid) 20 mg, Senna (a stool softener) 8.6 mg, and Guaifenesin (cough and cold medication) 600 mg. L. 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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	M. Record review of the nursing progress notes dated 12/27/21 at 21:24 (9:24 pm), EMTs (Emergency Medical Transport) arrived on scene. EMTs stated that pt was stable and that O2 was empty and that the O2 tank was not hooked up properly. EMTs stated that writer (LPN #9) was incompetent in regard to equipment and that since the pt had nail polish on her fingernails, that this was not an accurate reading. 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 (is an essential mineral and electrolyte that plays a critical role in many functions of the body) 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' suggestion to be transferred to hospital. There was no mention that the Physician was called following the visit by EMTs. N. Multiple attempts were made to contact R #210's family throughout the survey however never received a return call. O. 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 contacted. OMI (Office of the Medical Investigator) also contacted. P. On 03/29/22 at 7:39 am during an interview, RN (Registered Nurse) #1 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. Q. On 03/29/22 at 1:11 pm, during an interview, Center Executive Director (CED), when asked if the medications that were given the evening on 12/27/21 had been pre-poured before there given he stated he didn't know. When he interviewed LPN #9, he did not ask that question. He stated that the 6 R's of medication administration: (Right drug, Right amount given, Right route, Right patient, Right time and Right record) were not followed. The CED stated that he was more focused on what happened after the medication error occurred. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R. On 03/30/22 at 9:46 am, during an interview, LPN #10 stated that the night of 12/27/21, she was working the night shift. LPN #9 asked her to help pass 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. S. Multiple calls were made to LPN #9 who no longer worked at the facility, however never received a return call. T. On 03/30/22 at 11:40 am during an interview with Medical Director (MD), she stated that Hydrazine, Oxycodone, and Tramadol should not be administered all at the same time and that this was 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 sent 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 needed to be closely monitored. U. 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 LPN #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 and her levels went back up and the EMT's arrived. 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 to. 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, CNA #8 stated no. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	V. On 03/31/22 at 2:28 pm, during an interview, RN #9, stated that the process of administering medications is that you look up the resident, pull their medications and pop into a cup and go and given them right away. She stated that yes interruptions do happen when passing medications and you stop what you are doing, lock them in the drawer until you can get back to them. She stated that she has pre-poured medications before, but not for more than two residents at a time. She stated that nurses do it to save time because of being short staffed. She stated that you have to work with another person who you trust. One person pops the medications and the other takes the medications to the resident. X. On 03/31/22 at 3:09 pm, during an interview, LPN #13, stated that he was not working the day of the 12/27/21, but he spoke with LPN #10 on the 27th because she [LPN #10] had called him. She told him that LPN #9 was behind with medications, so she helped pass medications on that hall. They decided that LPN #9 was going to pop the medication and LPN #10 as going to pass the medications. LPN #10 told him that she had messed up and gave the wrong resident (R #210) medications that were prescribed to another resident. LPN #13 stated that the practice of pre-pouring meds is 100% frowned upon. Y. On 04/04/22 at 4:29 pm, during an interview, RN #14, it was stated that the nurses at the facility have been pre-pouring medications.She stated that there had been times when she had pre poured up to 6 residents medications at a time. It was stated that management knew that the staff were pre-pouring medications. 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. IJ Plan of Removal: All residents have the potential to be affected by medication errors. All medication carts were observed for loose and pre-poured pills on 03/31/22. The facility medication passes will be observed twice daily and monitored for following medication administration process twice daily and monitored for following medication administration process beginning on 04/01/22. This will include monitoring for nurses/CMA's [Certified Medication Aides] giving medications to other staff to administer to resident and pre-pouring of medications. The Center Nurse Executive re-educated current licensed staff starting on 03/31/22 including the following: -Medication pass should never include pre-pouring medications, or handing it to another person to take to the resident. This is dangerous and can cause serious medication errors. -Medication process is exactly as the competency states. You pass your own medications, one person at a time while following the 6 rights of medication pass (right person, right time, right medication, right route, right dose and right to refuse). -If the resident refuses their meds, you document it as such and discard the medications, do not leave in the cart. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-No pills should be loose in your cart, including in medication cups. The removal of the IJ occurred on 04/01/22 at 2:30 pm. Verification of the POR and it's implementation was confirmed onsite.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 20412 Based on observations, interviews, and record review, the facility failed to: 1) Ensure that treatment/medication carts were kept locked when not in use; 2) Ensure that opened/accessed multi-dose vials (a vial of liquid medication that contains more than one dose of the medication) of medications that had expired, were being accessed beyond the 28-day manufacturer's recommendation; and 3) Ensure that expired medications and medical supplies were not stored with unexpired medications or medical supplies, that were readily available for resident use. These deficient practices could likely result in affecting the 111 identified residents listed on the facility's Resident Alphabetical Census list provided by the Center Executive Director (CED) on 03/14/22, by allowing residents and unauthorized staff access to unlocked treatment/medication carts and residents to receive medications that have lost their potency, or effectiveness. The findings are: Findings related to treatment/medication carts being unlocked: A. On 3/21/22 at 4:23 pm, during an observation and interview, a medication cart on the 100 hall was observed to be unlocked. Pills poured in a medication cup, a needle, and a box of haloperidol (a medication used to treat certain mental/mood disorders) were observed in the top right hand drawer of the unlocked medication cart. LPN #14 demonstrated how the cart appeared locked but was unlocked. The top right drawer came out (opened) when it was pulled on-the rest of the drawers were locked. She reported that ithas not been happening and began checking all the drawers. All other drawers, except for the drawer with the prepped medications, remained locked when pulled on. LPN #14 stated sometimes the drawers get stuck and don't close all the way right. When asked if she had let someone know, she stated she should let someone know. She also stated medications are not supposed to be unlocked and then went to check on another resident, leaving the medications cart unsecured again. B. On 03/22/22 at 5:38 pm, during an observation, the treatment/medication cart for the 100 hall, was found to be opened. C. On 03/22/22 at 5:40 pm, during an interview, LPN (Licensed Practical Nurse) #2 stated, I had just stepped away from the cart. When asked if the treatment/medication cart should be locked at all times when not in use, she said, Yes, it should. D. On 03/23/22 at 1:34 pm, during an observation, the treatment/medication cart was unlocked, while 2 family members of a resident were in that hall standing by the cart. No facility staff were present. E. On 03/23/22 at 1:40 pm, during an interview, the Unit Manager confirmed that the treatment/medication cart should be locked at all times, when not in use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F. On 03/23/22 at 4:10 pm, during an observation, on top of the medication cart for 100 hall, was a bottle of Acidophilus (a bacteria that naturally exists in the body, helps to maintain an acidic environment in the body, can prevent the growth of harmful bacteria in the gut), sitting in a container with ice. G. On 03/24/22 at 2:30 pm, during an interview, RN (Registered Nurse) #1, when asked if the bottle of Acidophilus should be sitting on top of the medication cart in the hall, she stated, No. Findings related to expired medications and supplies being stored with active medications and supplies that are readily available for use; and expired medications that were dated when accessed were used after the manufacturer's recommendation: H. On 03/24/22 at 9:07 am, during an observation of the facility's medication storage room, the following was noted: The medication refrigerator contained the following: a. Three (3) opened multi-dose vials of Influenza Vaccine Quadrivalent (used to prevent and control Influenza (the flu): 1) One (1) multi-dose vial was dated as being opened on 10/29/21, the 28-day expiration date would have been on 11/26/21. This vial was being accessed and being administered to the residents, which would be 118 days, beyond the manufacturer's recommendation of 28 days, from the day that the multi-dose vial was first accessed; 2) One (1) multi-dose vial was dated as being opened on 11/03/21, the 28-day expiration date would have been on 12/01/21. This vial was been accessed and administered to the residents 113 days, beyond the manufacturer's recommendation of 28 days, from the day that the multi-dose vial was first accessed; and 3) One (1) multi-dose vial was dated as being opened on 12/12/21, the 28-day expiration date would have been on 01/10/22. This vial was being accessed and administered to the residents 73 days, beyond the manufacturer's recommendation of 28 days, from the day that the multi-dose vial was first accessed. In the medication storage room, the following was noted: b. Twelve (12) gold top vacutainer tubes (a sterile glass or plastic test tube with a colored rubber stopper creating a vacuum seal inside the tube, facilitating the drawing of a predetermined volume of liquid) that had expired on 10/31/21; c. One hundred fifty six (156) blue top vacutainer tubes expired on 10-31-20; and d. One hundred thirty eight (138) red top vacutainer tubes that had expired on 10-31-21. I. On 03/24/22 at 9:30 am, during an interview, the Corporate Nurse Representative confirmed that the three multi-vials of Influenza vaccine were expired and should have been discarded and that the vacutainer tubes were expired and also should have been discarded as well. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	J. Record review of the CDC (Centers for Disease Control and Prevention) website www.cdc.gov, revealed the following: If a multi-dose has been opened or accessed the vial should be dated and discarded within 28 days unless the manufacturer specifies a different date for that opened vial. K. Record review of the facility's policy and procedure titled Storage and Expiration Dating of Medications, Biologicals (are made from a variety of natural sources -- humans, animals or microorganisms (a microscopic organism which can be bacteria or fungus). Biological's are used to treat, prevent, or diagnose diseases and medical conditions), Syringes and Needles, last revision date of 12/13/17, revealed the following: .Facility should ensure that all medications and biological's, including treatment items are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors .Facility should ensure that medications and biological's that (1) have an expired date on the label, (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened .Medication with a manufacturer's expiration date expressed in month and year (e.g. May 2019) will expire on the last day of the month .Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis . 45426

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview, the facility failed to ensure that critical lab work (a process of collecting blood samples to determine therapeutic levels of medication in the body) was being reported to the ordering physician or on-call physician for 2 (R #210 and 211) of 2 (R #210 and 211) looked at for labwork. This deficient practice of not notifying the physician when critical labs have been called into the facility could likely result in health concerns worsening and could cause death if the concerns are not being addressed timely. The findings are: Findings for R #210 A. Record review of lab work collected on 12/26/21 at 19:21 (7:21 pm). The lab indicated that there was critically low lab result. R #210 had a potassium (is an essential mineral and electrolyte that plays a critical role in many functions of the body) level of 2.9. Normal levels are 3.5 -5.0. This lab was reported to the facility on [DATE] at 14:35 (2:35 pm). B. Record review of the Lab Results Report indicated that Medical Director (MD) viewed the lab work on 12/28/21 at 15:40 (3:40 pm). C. On 03/29/22 at 7:39 am, during an interview with RN #1, she agreed that the lab work that was completed for R #210 and indicated her Potassium was high. She stated that it could be a cardiac issue and when a critical lab comes in they (nursing staff) are supposed to call the physician or the on-call physician to receive further orders. D. On 03/30/22 at 10:38 am during an interview with the Medical Director (MD) she stated that as far as her providers are concerned they should be keeping up with the labs they order. She has started to move away from depending on the facility staff to notify the providers of abnormal and critical lab work. She stated that a 2.9 potassium is low. R #210 was on lasix (reduces fluid in the body) and it causes potassium to be low. The result came in to the facility on the 27th (December) at 2:35 pm. From what she can tell it doesn't look like they (facility staff) were notified the provider. She stated that the 27th was a Monday. The Physician was not notified and yes, the on-call provider should have been notified. Findings for R #211 E. Record review of lab work collected on 04/03/22 at 17:40 (5:40 pm). The lab indicated that there was critically high lab result. R #211 had a Bilirubin (an orange-yellow pigment formed in the liver by the breakdown of hemoglobin and excreted in bile and passes through the liver and is eventually excreted out of the body) of 9.2, Normal levels are 0.3-1.0. This lab was reported to the facility on [DATE] at 12:32 am. F. Record review of the nursing progress notes and physician orders did not indicate that the lab work was reported to the on-call provider. (continued on next page)

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Skies Healthcare & Rehabilitation Center	9150 McMahon Boulevard NW Albuquerque, NM 87114

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. Record review of the Lab Results Report indicated that no provider had viewed the lab work on 04/06/22 at 15:03 (5:03 pm). H. On 04/06/22 at 5:09 pm, during an interview with the Nurse Practitioner #1 she stated that she was aware of the lab for R #211. She stated that she was just made aware of the lab because of the Registered Dietician, she notified her of it not the nursing staff. She stated that the Unit Managers are pretty good at notifying her of lab work but she is not sure what is happening on the night shift. I. On 04/06/22 at 5:14 pm, during an interview with Unit Manager (UM) and Corporate Quality Nurse (CQN), the UM stated they are putting a process in place to sit down with the NP (Nurse Practitoner) and go over the labs together. The UM stated that they asked the NP to look at the labs she orders herself (she has access to the results just like they do). The NP hasn't really agreed to that. The CQN stated that the nurses need to call the physicians. If it is after hours then they need to call the on-call providers to notify them. If it is a critical lab whoever is on-call should be notified right away. J. On 04/06/22 at 5:33 pm, during an interview with Licensed Professional Nurse (LPN) #14, she stated that the lab will call them and notify them of any critical labs. They will call the on-call provider and notify the on-call of the labs and to get orders. The nurses don't always know when the labs come in and the NP is good at looking for them. She stated that no one has told her that it is her responsibility to look at and report the labs.

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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. /

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 35632 Based on record review and interview the facility failed to have a qualified Social Worker who had a minimum of a Bachelor's degree in Social Work or a Bachelor's degree in a Human Services field and one year supervised experience. This deficient practice could likely affect all 111 residents identified on the resident census list provided by the Administrator on 03/21/22 by not providing A. Record review of the extended survey binder provided by the Center Executive Director #2 (CED) indicated that the license on file was for the previous Social Worker (SW) /Social Services Director (SSD)and not the current SW/SSD. B. On 04/07/22 at 10:18 am, during an interview with the Interim Center Executive Director (CED) she stated that the facility is currently licensed for 124 beds and the Social Services Director (SSD) does not meet the minimum qualifications and is not being supervised by a licensed/certified SSD.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 35632 Based on record review and interview the facility's Quality Assurance Performance Improvement (QAPI) Committee failed to identify, develop and implement a plan of action to correct identified serious issues with medications, residents personal clothing not being delivered back to them, and resident labwork not being reported promptly to the physician for all 111 residents identified on the facility census given by the Center Executive Director on 03/21/22. This lack of action could likely create continued harm to residents due to a lack of tracking and analysis. The findings are: A. On 04/07/22 at 2:23 pm, during an interview with Center Executive Director #2, he stated that they are 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 10/01/21 he was unable to locate any information. B. On 04/07/22 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 were being worked on in her department, Quality Assurance Performance Improvement (QAPI): were call lights being answered timely and some infection control issues. C. On 04/07/22 at 2:34 pm, during an interview with Unit Manager #1, she stated that she has been here [employed] starting on 10/01/21 to the present. She didn't really re-call what was being discussed in QAPI. D. On 04/07/22 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 areas 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. E. No records were provided while on survey, of QAPI notes, process, or sign in sheets.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 40795 Based on observation, interview, and record review, the facility failed to maintain Infection control practices by not; 1. Providing a clean Breathcall (brand name of a resident call light system that is activated by a resident blowing into, to signal for assistance), a disposable filter assembly (clear plastic disposable mouth piece resident blows into, to activate call light) for 1 (R #60) of 1 (R #60) assessed for clean disposable filter assemblies, 2. Designating a holding area for an ice scooper outside of an ice chest; and ensuring ice scoopers are maintained in the designated holding area, and 3. Washing and sanitizing resident water pitchers for all 111 residents on the census provided by the administrator on 03/21/22. These deficient practices could likely result in a bacterial infection due to; the contamination of ice, poor sanitary practices related to cleaning water pitchers, and lack of changing out soiled disposable filter assemblies. The findings are: A. On 03/29/22 at 3:20 PM, during an interview with Kitchen Aid #1, when asked if the water pitchers are presented in large numbers for washing every night, she replied They come whenever. Currently, I have this bin of 14 pitchers and this has been here since the day before yesterday. When asked if there were more pitchers in addition to the bin she confirmed no. B. On 03/29/22 at 3:23 PM, during an interview with the Infection Control Nurse, she confirmed that education should be done to ensure that the aids are bringing fresh water pitchers to the residents on a nightly basis. 45426 Findings related to ice scooper: C. On 03/28/22 at 3:03 pm, during an observation, a large ice scooper was left inside the 200 hall ice chest. D. On 03/29/22 at 3:12 pm, during an interview with the Infection Control Nurse, when asked if the ice scooper should be left inside the ice chest, she confirmed, no. When asked how resident water pitchers are cleaned, she explained, The pitchers should be rotated out every night. They should be taken to the kitchen every night for cleaning. We have yellow and gray water pitchers. There is a color coded system where they should be rotating the pitchers on a nightly basis. Findings related to the ice scooper should be together. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	E. On 03/21/2022 at 6:00 PM, during an observation and interview on the 200 unit, a very large ice scooper was observed inside the ice chest, directly on the ice. CNA (Certified Nursing Assistant) # 14 stated that it is not supposed to be in the ice chest. She stated the ice scooper was too big for the covered container that the ice scooper is supposed to be kept in. CNA #14 stated the scooper falls out on the floor and she washes it. She also informed if the ice scooper is left on the table, the residents touch it. The ice scooper should be kept in the ice scoop holder, which has a lid to keep it covered. F. On 04/04/22 at approximately 10:20 am, during an observation on the 400 unit, a resident was seen reaching into the ice chest on the cart. The resident was attempting to get ice to fill her own cup. The resident was intercepted by CNA #10 who got ice for the resident. G. On 04/04/22 at 4:17 PM, during an observation, the ice scooper was observed setting directly on the cart in front of the ice chest and not in the designated holder. H. On 04/07/22 at 1:54 PM, during an observation and interview on the 400 unit, the ice scooper for the ice chest was observed directly on the cart and not in the designated ice scooper holder. Residents were observed walking and moving about on the unit in the 400 hallway; however, no facility staff were visible or present in the hallway. During an interview with the Infection Control Nurse, she confirmed that the ice scooper should be in the covered ice scooper holder and not on the cart directly. When asked if it were a problem for residents to get ice for themselves, she stated yes, residents should not be getting ice themselves. She stated the ice chest may need to be moved closer to the main nursing station so that it could be observed by those staff at the desk when no staff are present in the 400 unit hallway. Findings for R #60: I. Record review of R #60's medical record revealed R #60 was diagnosed with the following diagnoses: quadriplegia (paralysis of all four limb), unspecified; weakness; muscle weakness (generalized); and chronic gingivitis (a form of gum disease), plaque (a sticky deposit on teeth) induced. These diagnoses are not comprehensive and do not include all of R #60's active diagnoses. J. On 03/22/22 at 3:11 PM, at approximately 5:30 PM, during an observation and interview, R #60 informed that his call light was out of his reach. He asked if it could be adjusted to within his reach, which is in front of his mouth. To activate the call light, he must blow through it. The Breathcall (Brand name for a call light for disabled residents. The call light is activated by blowing or puffing air through it) call light was observed to consist of a flexible metal neck and a disposable filter assembly (clear plastic disposable mouth piece resident blows into, to activate call light). The filter assembly was observed twisted back and pointing to the rear wall behind R #60's headboard. The filter assembly nearly touched the wall, and was located high above R #60's head and left shoulder. It was out of his reach. R #60 stated he could not ask his roommate to push his call light on the roommate's side of the room, for assistance, because R #60 only spoke English and his roommate only spoke Spanish. There was a significant amount of build-up of a black, brown, and white residue within the filter assembly. The residue covered the entire length of the clear part of the assembly and all the inner walls of the cylinder-shaped assembly. The clear portion of the filter assembly was approximately 3 inches long, with an approximate 1/2 inch diameter tube. (continued on next page)

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	K. On 03/22/22 at 5:35 PM during an interview and observation, RN (Registered Nurse) # 1, verified that R #60's call light was out of his reach. She adjusted it was within his reach, in front of his mouth. RN #1 then removed R #60's filter assembly. Replacement filter assemblies were not readily accessible on the unit to the floor staff and required some effort and time for RN #1 to locate. Reading from the filter packaging, she informed that the manufacturer's instructions recommended the disposable filter assembly be replaced regularly or when it becomes unclean. RN #1 confirmed the filter assembly she had removed was visibly soiled and was unclean. She replaced it with a new filter assembly. RN #1 did not state when the last time R #1's filter assembly had been replaced. L. On 03/30/22 at 3:00 PM, during an interview, CNA #10 stated that she had noticed R #60's filter assembly was dirty. When she had noticed that it was dirty, she stated she had tried cleaning it by inserting an object into the assembly to scrape it clean. M. On 03/30/22 at 3:10 PM during an interview, Licensed Practical Nurse (LPN) #13 stated that CNAs are allowed to replace the filter assembly. They should not attempt to clean the filter assembly. LPN #13 stated the CNAs would need to be educated on replacing the Breathcall filter assembly and not attempting to clean a dirty, disposable filter assembly. He also stated the filter assemblies for R #60 were usually kept in the medication cart on the floor, however, he was unable to locate them when he attempted to show where they were kept in the medication cart. N. Record review of the manufacturer's instructions for the Breathcall Filter Assemblies, found at dwyerprecisionproducts.com (undated), stated Installed with slight pressure and twisting motion into top of assembly .The filter assembly is mainly to stop saliva (mucus membrane) and/or foreign matter from going down the airway and clogging the call unit itself .It is recommended that the filter assembly be replaced regularly (every 3 to 5 days, or when it becomes unclean).

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

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40795 Based on observation and interview, the facility failed to ensure that a functioning call light system was available for 2 (R #3 and R #77) of all residents who were residing on the 200 hall according to the census provided by the administrator on 03/21/22. This deficient practice could likely result in residents not being able to request assistance when needed. The findings are: A. On 03/23/22 at 10:54 am, during an interview, R #3 was reaching for the call light cord which was located on the floor. She then explained that she yells when it is not in reach and sometimes it pops out of the wall because it is too short. B. On 04/07/22 at 10:59 am, during an interview with Licensed Practical Nurse (LPN) #13, when asked if R #3 calls into the hall, he explained I have heard her calling into the hall. Usually it's because someone is not answering the call light fast enough. When asked if he has observed the call light out of the wall, he explained, There was an occasion where it was unplugged but usually she just says that the CNA's [Certified Nursing Assistants] aren't answering the lights. When asked if the call light for R #3 had been reported to maintenance, he replied, We did tell maintenance about the loose fitting call light fixture, but I don't know if they have completed it. C. On 04/07/22 at 11:39 am, during an interview with Maintenance, when asked if a work order for the call light fixture for R #3, who resides in room [ROOM NUMBER], was reported, he replied, no. D. On 04/07/22 at 11:47 am, during an interview with Maintenance, the call light for R #3 was examined and Maintenance confirmed that it falls out of the wall easily for both call light fixtures in room [ROOM NUMBER]. Further examination of all call lights in each room of the 200 hall revealed that the cord for R #77 was also loose and easily falls out of the fixture.