STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to ensure one (#1) of three residents out of 16 sample residents had the right to be informed of and participate in care plan meetings and to develop his or her treatment plan including the right to be informed, in advance, of the care to be furnished and the type of caregiver or professional that would furnish care. Specifically, the facility failed to: -Inform Resident #1's legal representative in advance of the facility's scheduled care plan meetings so the representative could participate in care planning; -Inform Resident #1's legal representative of when upcoming podiatry and dental services were to be provided so the representative could be informed and assist with treatment decisions; and, -Notify and inform Resident #1's legal representative of changes in the resident's condition, including falls. The findings include: I. Facility Policy and Procedure On 6/13/24 the Resident Representative policy, revised February 2021, was provided by the director of nursing (DON) on 6/13/24 at 3:30 p.m. The policy read in pertinent part, The facility treats the decisions of the resident representative as the decisions of the resident to the extent delegated to by the resident or to the extent required by the court, in accordance with applicable law. A resident who has been found to be incompetent by the state court has the right to appoint a resident representative who may exercise the resident's rights to the extent provided by state and federal law. The Resident Participation - Assessment/Care Plans policy, dated 2021, was provided by the DON on 6/13/24 at 3:30 p.m. The policy read in pertinent part, The resident and his or her representative are encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan. Spouses and other members of the family may participate in the resident assessment and development of the person centered care plan with the resident's permission. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident/representative's right to participate in the development and implementation of his or her plan of care includes (but is not limited to): -Participating in the planning process; -Requesting revision to the care plan; -Participating in the type, amount, frequency and duration of care; -Being informed, in advance of changes to the plan of care; and, -Refusing/requesting changes to and/or discontinuing care or treatment offered or proposed. The care planning process: -Facilitates the inclusion of the resident and/or representative; -Holds care planning meetings at times of the day when the resident, representative and family members can attend and are functioning at their best; and, -Provides sufficient notice in advance of the meetings. II. Resident #1 A. Resident Status Resident #1, age 76, was admitted on [DATE] and discharged to another facility on 5/5/24. According to the May 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia with behavioral disturbance and chronic kidney disease. According to the 3/9/24 minimum data set (MDS) assessment, the resident had severe cognitive impairment and was not able to complete the brief interview for mental status (BIMS) assessment. The staff assessment for mental status revealed the resident usually understood others and had difficulty communicating some words or finishing thoughts but was able to communicate when prompted or given time, however, the resident missed some parts or intent of conversations. The resident had short and long-term memory problems and had moderately impaired cognitive skills for daily decision making for which the resident required cues and staff supervision. B. Resident representative interview Resident #1's legal representative was interviewed on 6/13/24 at 6:13 p.m. The representative said the facility had a care conference meeting on 3/8/24 without informing her in advance of the meeting and then called her after the meeting and left a two and a half minute voice message where the staff member read the meeting minutes over the phone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's representative said that the phone call when the facility left the voicemail to summarize the care conference meeting was the first time she had been told about the frequency of the resident's falls. She said she had only been notified of one fall when the resident was injured and had to go to the hospital. The resident's representative said the voicemail was the first time she was informed that Resident #1 had been seen by a dentist, dental hygienist and podiatrist. The resident's representative said when she questioned the facility's social services assistant (SSA) about not being informed in advance of the planned care conference meeting, the SSA told her she did not have enough time to send out a letter inviting her to the care conference. The SSA did not offer the representative an alternative opportunity for the representative to meet with the interdisciplinary team (IDT) to discuss and give input into the revisions of the resident's care plan. The resident's representative said, in addition to not notifying her of the care conference meeting, the facility only notified her of one of the resident's falls that had occurred earlier in the year, and they failed to notify her that the resident was seen by a dentist, a dental hygienist and a podiatrist. The resident's representative said what was most concerning in regards to not being notified was that she was in the facility every day around lunchtime to visit with Resident #1 and still she had not been notified of all of the changes in the resident's care, condition and treatment services so that she could take an active role in the resident's care. C. Record Review A care conference invitation letter addressed to the resident's legal representative and the resident's durable power of attorney for health care and financial decision-making (DMPOA/DFPOA), dated 2/29/24, was provided by the DON on 6/14/24. It read in part There will be a resident care plan conference for Resident #1 on Friday 3/15/24 at 1:00 p.m. The conference is scheduled to last about 15 minutes. -However, Resident #1's care conference meeting was held on 3/8/24 instead of 3/15/24 (see representative's interview above and progress note below). The social services review assessment, dated 3/8/24 and completed by the SSA, documented the resident's spouse was very involved in the resident's care. The resident was easily distracted and provided nonsensical answers to questions asked. The resident's legal representative was appointed as the resident's DMPOA/DFPOA. A care plan conference summary note dated 3/8/24 revealed the care planning meeting was held without the resident's legal representative present. The IDT discussed the resident's fall history, medications, hospice care, ambulation status and appointments with the dentist and hygienist. The IDT also discussed the resident's advanced directives and do not resuscitate status. -A review of the resident's comprehensive care plan, revised on 4/19/24, revealed no interventions to keep the resident's representative involved in care or informed of changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no care plan documenting the need for ancillary services including dental or podiatry services. A podiatry note dated 3/1/24 revealed the resident was seen as a new patient by the podiatrist and was assessed and treated for long dysphoric (deformed, thickened and discolored) nails. Several issues were diagnosed , including nail dystrophy (abnormal changes of the nail often caused by fungus), corns and callosities (thickened skin) and a missing toenail. Keratin debris toenail treatment (removal of fungus from the nail) was provided using nail nippers during the visit. -A review of the resident's electronic medical record (EMR) revealed there was no documentation to indicate the resident's legal representative was informed of the resident's appointments so she could attend the appointment and participate in treatment planning. There was no documentation to indicate the representative was informed of the outcome of the appointment. -Additionally, the EMR revealed no documentation of the resident's dental services. C. Staff Interviews Licensed practical nurse (LPN) #3, who was the memory care unit manager,was interviewed on 6/12/24 at 1:36 p.m. LPN #3 said the facility did not notify the residents' representative when the resident attended in-house or routine appointments for the dentist, podiatrist or eye doctor. She said the residents' representative would be notified if there was something out of the ordinary scheduled for the resident, such as a tooth extraction or a need for new glasses. The SSA was interviewed on 6/12/24 at 1:38 p.m. The SSA said she was responsible for setting up ancillary (dental, eye doctor and podiatry) medical appointments, most of the time at a resident's or family member's request, but she did not notify the resident's representative of upcoming routine doctor and ancillary visits. The SSA said sometimes she did not know that the resident was scheduled to be seen until the day of the appointment. The SSA said the IDT set up and scheduled upcoming care conference meetings and then she sent out a letter to invite the resident and the resident's representative/family, as applicable. The SSA said the facility only called the resident's representative/family members when there wasn't enough time to send a letter out in the mail. The SSA said the facility held care conference meetings based on the IDT's availability and if the family members could not attend the meeting, she would meet with the family after the IDT met and read the IDT minute notes to the resident's representative. The SSA said she did send a letter to Resident #1's representative for the March 2024 care conference meeting. -However, the care conference invitation letter provided (see record review section above) documented that the care conference was to be held on 3/15/24 and the meeting per the care conference summary notes was held on 3/8/24 (see record review above). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 6/13/24 at 11:05 a.m. The DON said the facility was having problems setting up care conference meetings so that the residents' representatives could attend and participate in the care planning process. She said everyone was scheduling meetings differently so they streamlined the process for consistency and accuracy of the dates of the care conference meetings. The DON said the procedure for scheduling care conference meetings was for the social services department to set up care conferences using the facility's scheduling system and invite staff to attend. The DON said an email was sent to the residents' family to invite them to the care conference and the facility maintained a copy of all emails sent to the families. She said if the family did not use email, the social worker would set up another method of notification that met the needs of the resident's family/representative. The DON said the family was only notified of a care conference meeting by phone if the resident was newly admitted . The DON said the social services department should notify the resident and resident representative of all scheduled ancillary visits so they could decide if they wanted treatment and so the representative could decide if they wanted to be present during the visit. The DON said there was no reason Resident #1's representative had not been informed of the resident's treatments and changes in condition because the representative was in the facility every day to visit Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on interviews and record review, the facility failed to protect and keep residents safe from abuse and neglect for two (#2 and #11) of three residents reviewed for abuse out of 16 sample residents. A review of resident records and interviews with staff revealed the facility failed to take steps to develop and implement effective interventions to create an environment in the memory care-secure unit that protected residents from resident-to-resident abuse. RESIDENTS #6 AND #2 On 4/8/24, Resident #6 was admitted to the facility's memory care-secured unit. It was known to the facility, before the resident's admission, that he was displaying an increase in unsafe wandering and physical and verbal aggression toward other residents at the facility where he had previously resided. Resident #6 was discharged from his previous facility to the hospital due to his aggressive behaviors and remained at the hospital waiting until another long-term care facility placement could be obtained. A pre-admission long-term care (LTC) level of care eligibility assessment completed on 3/27/24 at the hospital documented Resident #6 exhibited inappropriate behaviors that put himself and others at risk and he frequently required more than verbal redirection to interrupt inappropriate behaviors. During the admission process, the facility failed to fully assess Resident #6's care needs and develop and implement a behavioral management care plan with interventions to monitor his behavior through his transition and adjustment to the facility's secured memory care unit and to prevent Resident #6 from being aggressive towards other residents residing in the facility. Additionally, the facility failed to inform the facility staff about the resident's history and increasing aggressions that led to his discharge from the previous facility where he had resided. In the first 48 hours of Resident #6's stay in the memory care unit, staff did not identify the resident's behaviors were becoming more aggressive. There was no reassessment of Resident #6's care needs despite staff observing changes in his demeanor from being extremely polite and asking for permission to do things, to wandering the unit and engaging in aggressive behaviors, which included rude mocking and bullying towards the unit's other residents. On 4/10/24 at approximately 5:00 p.m., Resident #2 was in her bed for the night. Licensed practical nurse (LPN) #1 heard moaning noises and a second person making mocking noises following each of Resident #2's moans. LPN #1 went to check on the resident and discovered Resident #6 on top of Resident #2 punching her in the face several times with a closed fist. LPN #1 called for additional staff assistance to separate the residents. Resident #2 suffered severe injuries to her face and body as a result of the physical assault. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Because the staff did not have a full history of Resident #6 behavior or assess the resident's care needs and develop a behavior-focused care plan with interventions to monitor and treat potential aggressive behaviors, they failed to monitor Resident #6's activities closely enough to prevent him from physically assaulting Resident #2 who was incapable of protecting herself. As a result of the facility's failures, Resident #2 suffered significant facial trauma, including a subdural hematoma (pooling of blood between the brain and its outermost covering), left frontal scalp hematoma (pooling of blood outside of a blood vessel and under the skin), frontal process of the maxilla (upper jaw) fractures, nasal septum (cartilage between the right and left nostril) fractures, hemorrhaging of the right parietal gland (gland located on each side of the face just below the ears), left periorbital (area around the eye) soft tissue hematoma and bilateral sacral (the bone located at the base of the spine) fractures. Resident #2's injuries required hospitalization and ongoing monitoring of her injuries. Although Resident #6 was discharged from the facility on 4/10/24 due to the incident involving Resident #2, record review and interview revealed the facility failed to identify and correct gaps in its screening and admission process. Specifically, the facility failed to consider and implement practices to obtain and communicate information that would ensure an admission was safe and appropriate for the newly admitted residents and residents who were already settled in the facility. Further, the facility failed to consider and implement practices to screen prospective residents with behavioral needs to ensure the facility could provide care as identified during the screening assessment. The facility's failures in its screening and admission process and the communication to staff of the information obtained during this process created a situation of immediate jeopardy with the potential for serious harm to other residents residing in the facility's memory care-secured unit. RESIDENTS #5 AND #11 Record review revealed the facility failed to take sufficient steps to prevent Resident #5 from physically abusing Resident #11 who Resident #5 hit when Resident #11 wandered into Resident #5's room. Resident #11 sustained a bloody nose and cuts to his face. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy A review of resident records and interviews with staff revealed the facility failed to take steps to develop and implement effective interventions to create an environment in the memory care-secure unit that protected residents from resident-to-resident abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/8/24 Resident #6 was admitted to the facility's memory care-secured unit. It was known to the facility, before the resident's admission, that he was displaying an increase in unsafe wandering and physical and verbal aggression toward other residents at the facility where he had previously resided. Resident #6 was discharged from his previous facility to the hospital due to his aggressive behaviors and remained at the hospital until placement in another facility could be obtained. A pre-admission long-term care (LTC) level of care eligibility assessment completed on 3/27/24 at the hospital documented Resident #6 exhibited inappropriate behaviors that put himself and others at risk and he frequently required more than verbal redirection to interrupt inappropriate behaviors. During the admission process, the facility failed to fully assess Resident #6's care needs and develop and implement a behavioral management care plan with interventions to monitor his behavior through his transition and adjustment to the facility's secured memory care unit, and to prevent Resident #6 from being aggressive towards other residents residing in the facility. Additionally, the facility failed to inform the facility staff about the resident's history and increasing aggression that led to his discharge from the previous facility. In the first 48 hours of Resident #6's stay in the memory care unit, staff did not identify that the resident's behaviors were becoming more aggressive. There was no reassessment of Resident #6's care needs despite staff observing changes in his demeanor from being extremely polite and asking for permission to do things, to wandering the unit and engaging in aggressive behaviors, including rude mocking and bullying towards the unit's other residents. On 4/10/24 at approximately 5:00 p.m., Resident #2 was in her bed for the night. Licensed practical nurse (LPN) #1 heard moaning noises and a second person making mocking noises following each of Resident #2s moans. LPN #1 went to check on the residents and discovered Resident #6 on top of Resident #2 punching her in the face with a closed fist. LPN #1 separated the residents. Resident #2 suffered severe injuries to her face and body as a result of the physical assault she endured. Because the staff did not have a full history of Resident #6 or a care plan with interventions to monitor and treat potential aggressive behaviors, they did not monitor Resident #6's activities closely enough to prevent him from physically assaulting Resident #2 who was incapable of protecting herself. As a result of the facility's failures, Resident #2 suffered significant facial trauma, including a subdural hematoma (pooling of blood between the brain and its outermost covering), left frontal scalp hematoma (pooling of blood outside of a blood vessel and under the skin), frontal process of the maxilla (upper jaw) fractures, nasal septum (cartilage between the right and left nostril) fractures, hemorrhaging of the right parietal gland (gland located on each side of the face just below the ears), left periorbital (area around the eye) soft tissue hematoma and bilateral sacral (the bone located at the base of the spine) fractures. Resident #2's injuries required hospitalization and ongoing monitoring of her injuries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although Resident #6 was discharged from the facility on 4/10/24 due to the incident with Resident #2, record review and interviews revealed the facility failed to identify and correct gaps in its screening and admission process. Specifically, the facility failed to consider and implement practices to obtain and communicate information that would ensure an admission was safe and appropriate for the newly admitted residents and residents who were already settled in the facility. Further, the facility failed to consider and implement practices to screen prospective residents with behavioral needs to ensure the facility could provide care as identified during the screening assessment. The facility's failures in its screening and admission process and the communication to staff of the information obtained during this process created a situation of immediate jeopardy with the potential for serious harm to other residents residing in the facility's memory care-secured unit. B. Facility notice of immediate jeopardy On 6/13/24 at 4:15 p.m., the director of nursing (DON) and corporate nurse consultant (CNC) #1 were notified the facility's failure to ensure its new resident admission screening process was effective and created an environment in the memory care-secure unit that protected residents from resident-to-resident abuse, created a situation of immediate jeopardy with the potential for serious harm if not immediately corrected. C. Plan to remove immediate jeopardy On 6/14/24 at 2:36 p.m., CNC #1 and the DON presented the following plan to address the immediate jeopardy situation. It read in pertinent part: Plan to remove Immediate Jeopardy Immediate Action Done Resident# 6 was discharged from the facility. On 6/13/24, Resident #5 was placed on one-to-one monitoring. Will continue one-to-one support and will review with the interdisciplinary team (IDT) team on 6/18/24. The facility will hold admissions until it can review the pre-admission screening tool for residents with known behaviors. Once the review is completed, an ad hoc (done for a particular purpose) quality assurance performance improvement (QAPI) meeting will be held. The abuse policy was reviewed on 6/13/24. On 6/14/24, the nurse practice educator (NPE)/designee educated all staff on the facility abuse policy. Staff not educated on this date will be educated prior to their next shift. On 6/14/24, facility management staff reviewed the facility assessment on staffing and skills to care for residents with behaviors. Plan: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning 6/14/24, the facility revised its pre-admission screening intake form to include a history of behaviors and supervision needs by the admissions director. This will be an ongoing process. The admission team will review electronic records and utilize the pre-admission screening tool. Pre-admission screening forms will be reviewed with nursing, social services, and administration to determine if the facility can meet the needs of residents based on the screening process or if additional information is needed to decide. On 6/14/24, the director of nursing educated the admissions team on the pre-admission screening tool and process. Beginning 6/14/24, residents in the memory support unit will be reviewed by social services and/or nursing/designee for behaviors, wandering, current interventions, and their care plan related to behaviors. This review will be completed by 6/21/24. Upon completion of the review, staff who are assigned to the memory support unit will be trained in specific resident care needs. The training will be completed prior to their next assigned shift. Any admission to the memory support unit will be reviewed by social services and nursing to enter behavior tracking and a baseline care plan to meet the resident's needs. The facility assessment was reviewed and revised to include staffing levels for all departments in the memory support unit. New hires will receive education on abuse prevention and de-escalating behaviors during onboarding by the NPE (nurse practice educator). The nursing home administrator (NHA) will implement a review with the quality assurance performance improvement (QAPI) committee to review and interpret all abuse findings. All audit findings will be reviewed at the monthly meeting for at least three months or until the compliance pattern is maintained. D. Removal of immediate jeopardy On 6/14/24 at 3:30 p.m., the DON and CNC #1 were notified that the facility's plan to remove the immediate jeopardy was accepted based on the facility's plan to implement the measures above. However, the deficient practice remained at a G level, isolated, actual harm. II. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation Prevention Program policy, revised April 2021, was received from the DON on 6/14/24 at 10:30 a.m. The policy read in pertinent part, Residents have the right to be free from abuse. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to, facility staff and other residents. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and responding to abuse, stress management, and handling verbally or physically aggressive resident behavior. Implement measures to address factors that may lead to abusive situations, for example: -Adequately prepare staff for caregivers' responsibilities; -Provide staff with the opportunity to express challenges related to their job and work environment without reprimand or retaliation; -Instruct staff regarding appropriate ways to address interpersonal conflicts; and, -Help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts. III. Resident-to-resident physical abuse between Resident #6 and Resident #2 A. Resident #2 (victim) 1. Resident status Resident #2, age 89, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included dementia without behavioral disturbance, depression, and disorder of bone density. The 4/25/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment and was unable to complete the brief interview for mental status (BIMS). The resident had short and long-term memory problems and was unable to recall staff names or faces, the location of her room, and was unaware she was in a nursing home facility. The resident had unclear speech and only sometimes understood conversations and responded only to direct communication. The resident was dependent on staff for bed mobility, toilet use, and transfers and was unable to walk. 2. Record review A hospital service report, dated 4/11/24, documented Resident #2 presented to the emergency room (ER) on 4/10/24 via EMS (emergency medical services) for evaluation after she sustained an assault. The resident was residing at a memory care facility when a staff member found the patient in her bed with another patient on top of her and hitting her in the face with a closed fist. Per EMS, staff denied any loss of consciousness and stated she was nonverbal at baseline. Imaging was obtained by the ER provider with findings of a subdural hematoma, bilateral sacral fractures, frontal processes of maxilla and nasal septum fracture, injury to the right parotid gland, facial and left periorbital soft tissue hematomas. The ER provider consulted neurosurgery who recommended the resident be admitted to the floor. Facial trauma was also consulted by the ER provider. The ER provider consulted trauma surgery services for admission and medical management. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2 discharged from the hospital on 4/12/24 with a referral to see a neurosurgeon within two weeks of discharge. She was to follow up with facial trauma specialist as needed and follow up with her primary care physician in one week for further medical management and refill of medications. A nurse practitioner exam note dated 4/29/24 documented Resident #2 had increased weakness since she was assaulted, per reports from nursing staff. The resident used to feed herself and was now requiring assistance with meals. The resident was previously a two-person assist for transfers and was now requiring the use of a sit-to-stand lift for transfers. A neurosurgical consult follow-up dated 5/7/24 documented the subdural hematoma collections had resolved with no increase in intracranial hemorrhaging and further treatment was not warranted. B. Resident #6 (assailant) 1. Resident status Resident #6, age 70, was admitted on [DATE] and discharged to the hospital on 4/10/24. According to the April 2024 CPO, diagnoses included cerebral palsy, dementia, and major depression. The 4/10/24 discharge MDS assessment revealed the resident needed partial to moderate assistance with toileting hygiene; putting on and taking off footwear; and with dressing and grooming. He was independent with chair-to-chair transfers, rolling left to right, sitting, and lying down. The resident was able to walk short distances but was using a manual wheelchair to get around. The assessment documented the resident was prescribed antipsychotic and antidepressant medications. 2. Record review A hospital admission summary dated 3/16/24 documented Resident #6 had a pertinent history of dementia with behavioral disturbance and presented to the hospital for chief complaints of agitation. The patient was at an assisted living memory care facility (facility name) where, according to EMS, he had attacked people in the past. Per EMS, they were called because he was in the common area and was screaming and inconsolable. A referral for placement dated 3/21/24 documented Resident #6 presented to the emergencyER on [DATE] for agitation. The facility where he lived was unable to handle him anymore. The facility would not take the resident back due to his behavior and he has been in the ER awaiting placement. The resident would be very difficult to place given his history of aggression/agitation. While in the hospital, Resident #6 was prescribed the following psychotropic medications: Escitalopram oxalate (Lexapro) (an antidepressant medication) tablet 20 milligrams (mg) daily for depression and anxiety, ordered 3/17/24. Risperidone (an atypical antipsychotic medication) tablet 0.5 mg two times a day for agitation, ordered 3/16/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Trazodone (Desyrel) (a medication used for major depressive disorder) tablet 150 mg at bedtime for sleep, ordered 3/16/24. Quetiapine (Seroquel) (an antipsychotic medication) tablet 25 mg two times a day as needed for delirium or agitation, ordered 3/21/24. The medication was given during the resident's stay in the hospital. A LTC (long-term care) level of care eligibility assessment for Resident #6, dated 3/27/24, revealed the resident exhibited inappropriate behaviors that put himself, others, or property at risk and he frequently required more than verbal redirection to interrupt inappropriate behaviors. Resident #6 was assessed to be delusional with mood instability. He needed supervision due to aggressive behavior, agitation, disruption to others, impaired judgment, need for medication management, memory impairment, verbal abusiveness, and wandering behaviors. Per Resident #6's court-appointed guardian, the resident was asked to leave the memory center where he was living due to yelling, screaming outbursts, and hitting other residents and staff with his walker. The guardian reported the behaviors tended to happen in the late afternoon or early evening, and there were no known prompts for behaviors. Resident #6 could not verbalize when he was upset or identify why he was upset. Resident #6's baseline care plan, dated 4/10/24, revealed the resident was alert and oriented to self and needed cueing and prompts to complete activities of daily living. Resident #6's comprehensive care plan, initiated on 4/10/24, documented the resident was able to make his needs and preferences known. He was pleasant and cooperative. He used a wheelchair and could self-propel. His vision and hearing were adequate. He enjoyed watching television, listening to music, playing the harmonica, having conversations with staff, and napping. He passively participated in most scheduled activities. -Neither care plan included a behavior management focus or interventions to manage Resident #6's aggressive behaviors. A social services note dated 4/10/24 at 4:30 p.m. revealed Resident #6 was starting to show aggressive behaviors similar to behaviors he was displaying at his previous facility when he was discharged . The note documented that when Resident #6 was eating, he would wheel himself away from the table and run his wheelchair into other residents who were standing or passing nearby and he had to be redirected to the dining room table. C. Facility investigation of the incident between Resident #2 and Resident #6 A facility physical abuse investigation dated 4/10/24 revealed that on 4/9/24 at approximately 5:38 p.m., licensed practical nurse (LPN) #1 discovered Resident #6 on top of Resident #2 punching her in the face with a closed fist. Resident #6 was using his bodyweight to pin Resident #2's arms down while using his right hand to hit her in the face. LPN #1 called for help and staff separated the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately following the incident, Resident #2 presented with labored breathing and hyperventilation, repeated troubled calling out, loud moaning, groaning and crying, facial grimacing, rigidity, clenched fists, knees pulling up, pulling and pushing staff away, and striking out. The resident was inconsolable. Resident #2 showed signs of being in pain and had observable abrasions, lacerations, skin tears, and discoloration on her body. Resident #6 had no observable injuries. Emergency medical services (EMS) were called and Resident #2 was sent to the emergency room to be assessed for trauma and injuries. Resident #6 was sent out to the hospital for assessment and monitoring due to his aggressive behaviors. Staff witness statements Certified nurse aide (CNA) #1 was interviewed on 4/10/24 following the resident-to-resident physical assault. CNA #1 said she heard LPN #1 yelling for help. CNA #1 said she ran to the area of the call for help and encountered LPN #1 in the hall. LPN #1 instructed CNA #1 to respond to Resident #2's room to help. Upon entering Resident #2's room, CNA#1 observed Resident #6 punching Resident #2 in the face. Resident #6 would not stop. CNA #1 said CNA #2 arrived at the room and they pulled Resident #6 off Resident #2 by the back of his shirt and dragged him to the floor and out into the hall because he was hitting them as well. CNA #1 said Resident #6 was physically and verbally aggressive toward the staff intervening to stop the assault. CNA #2 was interviewed on 4/10/24 following the resident-to-resident physical assault. CNA #2 said between 4:30 p.m. and 5:00 p.m., she was in the other hallway assisting a resident to eat dinner when she heard LPN #1 yelling for help. CNA #2 said she responded immediately and witnessed Resident #6 punching Resident #2 nonstop in the face. She and another CNA (CNA #1) who responded to the call for help had to pull Resident #6 off of Resident #2 to get him to stop punching her. LPN #4 was interviewed on 4/10/24 following the resident-to-resident physical assault. LPN #4 said he was called to Resident #2's room to assist with Resident #6. LPN #4 said he arrived at Resident #2's room and saw Resident #6 on the floor in the hall sitting on the floor scooting back towards Resident #2's room. Resident #6 was redirected away from Resident #2's room. LPN #4 said Resident #6 had blood on his hands and Resident #2, still in bed, had blood on her face and her bed linens and her face had visible signs of swelling. LPN #4 said Resident #6 was starting to get physically aggressive with other residents in the common area. LPN #4 said he had to shield the other residents from Resident #6's physical aggression. Resident #6 then directed his aggression toward staff and began kicking LPN #4 in the legs. After approximately 10 minutes, EMS arrived, restrained Resident #6, and transported him to the hospital for assessment. -The facility failed to show they implemented any new process for their admission screening of new residents or assessed other residents for appropriate interventions for behaviors and behavior monitoring following the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	D. Staff interviews The DON was interviewed on 6/13/24 at 11:05 a.m. The DON said the facility had a marketing intake person who conducted initial screens on potential new admits and provided her with potential candidates for admission. The DON said she reviewed the available documentation that the recruiter or marketer gave to her to decide whether or not the facility could meet the individual's needs as a resident of the facility. The DON said if the documentation indicated the individual had behaviors she would have to look deeper. The DON said Resident #6's intake referral papers documented that he had behaviors that were resolved at the hospital, so the interdisciplinary team (IDT) allowed his admission to the facility. The DON said the IDT based admission decisions on the current information presented. She said that in the case of Resident #6, the facility was given limited information. She said the facility had no documentation from the resident's previous placement to review. -However, the facility knew the name of the previous facility the resident was discharged from and did not ask the resident's guardian for assistance in requesting treatment records from that facility for review before the resident's admission. Further, the facility was aware of the resident's extended hospitalization due to difficulty finding placement. The DON said the intake documentation did not raise red flags and it looked like Resident #6 presented with typical concerns. She said there was no indication that his behaviors would escalate to him becoming abusive towards the other residents. The DON said the referral just provided her with a snippet of information and if she had more information when reviewing the resident's intake, she would not have accepted him. The DON said she did not receive any information that Resident #6 had a history of aggressive behaviors toward other residents. She said she did not recall seeing the long-term care eligibility assessment (see record review above) and was not familiar with the assessment that the resident was verbally and physically aggressive towards others and required more than verbal redirection to interrupt inappropriate behaviors. -However, the long-term care eligibility assessment was uploaded to Resident #6's EMR on 4/8/24. The DON said Resident #6 was fine upon arrival. She said he was acclimating to the environment and was playing his harmonica. The DON said she was not aware that Resident #6 had displayed any behaviors before his assaulting Resident #2. The DON said the number one goal of the facility was to keep the residents safe and be a partner for the non-clinical needs. LPN #1 was interviewed on 6/13/24 at 1:20 p.m. LPN #1 said the day of admission (4/8/24), Resident #6 was pleasant and cooperative. Resident #6 was talking to staff and asking permission for everything. He said on the second day, in the evening, Resident #6's behavior started to change. He said Resident #6 was wandering around the unit and was mocking other residents' actions. LPN #1 said staff had to redirect him several times throughout the day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN #1 said when Resident #6 was admitted to the unit, he was told some past reports documented Resident #6 had been aggressive in the past but his record was sealed so they did not know exactly what happened at his previous facility. LPN #1 said when he arrived on shift on 4/10/24, he was informed by the previous shift staff that he needed to keep an eye on Resident #6 as he was mocking others in an inappropriate tone. LPN #1 said one example of his aggressive behavior was that one of the female residents was drinking coffee and expressing her pleasure of it uttering an mm-hmm sound. Resident #6 started mocking and mimicking her sound, getting louder and more aggressive in his actions. Resident #6 progressed and moved closer to her face and continued his mocking. LPN #1 said he had to approach Resident #6 to get him to stop. LPN #1 said later in the day, Resident #6 had to be redirected to the dinner table. He said after the resident was done he wandered from the dining room area. LPN #1 said Resident #6 was quick and quiet when wandering around and he did not notice him leaving the dining room. LPN #1 said it was very noisy in the dining room because the television was turned up loud and another resident was listening to his music, which also was loud. LPN #1 said, for some odd reason, the sound stopped and it got quiet in the room. He then heard moaning noises and heard another resident mocking the first resident's moaning sounds. LPN #1 said, thinking something was not right, he went down the hall to see what was going on. He said as soon as he arrived at the source coming from Resident #2's room, he saw Resident #6 on top of Resident #2. LPN #1 said at first, from the doorway, he thought Resident #6 was kissing Resident #2 but then he observed Resident #6 rocking backward and making a fist. He said Resident #6 made a moaning sound and punched Resident #2 in the face. LPN #1 said Resident #2 moaned when he punched her. LPN #1 said he immediately called for help and staff responded to assist in separating the residents. LPN #1 said Resident #2 was not able to move or defend herself. LPN #1 said Resident #2 was very distressed following the incident and was inconsolable. He said she was bleeding and crying and appeared to be in pain. He said EMS was called immediately so her injuries could be assessed and treated at the hospital. LPN #1 said Resident #2 returned to the facility two days later. He said the EMS provider reported that the resident was showing fear of male caregivers at the hospital and with the EMS providers. LPN #1 said resident-to-resident aggression occurred frequently in the unit but it had never been this severe. He said he worked four shifts a week and would estimate that, on average, there were two to three instances of resident-to-resident aggression each shift. He said most of the time the staff were able to intervene and redirect the residents before it rose to a physical altercation or abusive nature. Resident #6's legal guardian was interviewed on 6/13/24 at 9:00 a.m. The guardian said she talked with the facility during Resident #6's admission intake to request that they keep a close eye on him due to his unsafe wandering and past aggression because he was aggre[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin were reported immediately for one (#1) of three residents reviewed out of 16 sample residents. Specifically, the facility failed to report an allegation of an injury of unknown origin (bite wound) to the State oversight agency within 24 hours of the injury being discovered. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, revised September 2022, was received from the director of nursing (DON) on 6/14/24 at 10:30 a.m. The policy documented in pertinent part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of property are reported to the local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, misappropriation of resident property or injury of the unknown source is suspected, the suspicion must be reported immediately to the administrator and the other officials according to the state law. Immediately is defined as: -Within two hours of an allegation involving abuse or resulting in serious bodily injury; or -Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. II. Allegation of abuse -injury of unknown source (bite wound) On 4/9/24 the hospice provider and the resident's legal representative reported that Resident #1 had a bite wound on the top of his left hand. The cause of the bite wound was unknown and suspected to have been caused by someone other than Resident #1. III. Record review The State oversight agency facility reported incident portal was reviewed on 6/12/24. The review revealed that the facility had not reported the allegation of abuse identified by an injury (bite wound) of an unknown source. IV. Resident representative interview (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's representative was interviewed on 6/13/24 at 6:13 p.m. The representative said she was at the facility every day to visit with Resident #1. She said on the morning of 4/9/24 she received a call from Resident #1's hospice nurse asking if she knew about a bite mark on the top of Resident #1's wrist. The representative said that was the first time she was made aware that there was a bite mark on Resident #1's hand. The representative said she was at the facility the day prior (4/8/24) at lunchtime and the resident did not have the bite mark on his arm at that time so the injury had to have happened sometime after she left the faciity on [DATE] and the morning of 4/9/24. The representative said she went to the facility on the morning of 4/9/24, to find out what happened and observed the bite wound on Resident #1's arm. The representative said she talked to the staff on duty and no one knew that the resident had a bite wound and nobody could reasonably explain how the bite happened. The representative said she took a picture of the resident's wound to show the facility administration. The representative said she spoke to licensed practical nurse (LPN) #3, who was the memory care unit manager and asked her to find out how Resident #1 got the bite wound. The representative said she never heard anything further from facility staff about how Resident #1 got the bite mark on his hand or who bit him. The representative said she was concerned for Resident #1's safety. V. Staff interviews LPN #3 was interviewed on 6/12/24 at 1:36 p.m. LPN #3 said she had no knowledge of the resident having a bite mark on his arm. LPN #3 said she did not examine the resident's injury but was aware that the resident had some scratches on his person which were attributable to his wandering. The memory care unit social services assistant (SSA) was interviewed on 6/12/24 at 1:38 p.m. The SSA said Resident #1's representative mentioned that Resident #1 had a bite mark on his hand. The SSA said she did not see the bite mark and the resident's representative had made no further inquiry about the nature of the bite mark. The hospice registered nurse (HRN) was interviewed on 6/12/24 at 2:16 p.m. The HRN said the resident's hospice CNA called her on the morning of 4/9/24 to report that the resident had a wound on the top of his left forearm that looked like a bite mark. The HRN said the hospice CNA reported to her that the facility staff were unaware of how the resident got the wound. The HRN said she called the facility before calling the resident's representative but had to leave a voice message when the memory care unit manager (LPN #3) did not answer the phone. The HRN said when she called the resident's representative to see if she was at the facility or had knowledge of what happened to Resident #1, the resident's representative did not even know the resident had a bite mark wound on his person. The HRN said she assessed the resident's wound on 4/11/24 and cleaned the wound and bandaged it. The HRN said the wound on Resident #1's upper forearm at the wrist was definitely teeth impression marks. She said the bite was in a pattern of a full set of upper teeth and partial bottom teeth and it was in a placement pattern that was unlikely that the resident could have done it himself. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The HRN said she had concerns because Resident #1 was known to wander into other residents' rooms and was often injured as a result of some other residents being upset over his wandering behaviors. The HRN said there were a lot of residents on the unit who were physically aggressive toward other residents The DON was interviewed on 6/13/24 at 11:05 a.m. The DON said the facility did not have an investigation for the resident's bite wound and it was not reported to the State oversight office as an injury of unknown origin. The DON said she had heard about the allegation that Resident #1 had a bite mark on his arm so she asked one of the facility nurses to look at his arm. The DON said she did not examine the resident herself and could not remember which nurse she asked to look at the resident' s arm but she said she remembered the nurse reported the resident did not have a bite wound. The DON said she did not know why there was no documentation of the assessment of Resident #1 done by the nurse but said she would try to find out which nurse assessed the resident and look to see if the facility had any documentation of the allegation and the assessment of the resident. -The DON did not provide any additional evidence to indicate the allegation that Resident #1 sustained a bite wound of unknown origin was investigated or that the nursing staff assessed and monitored the resident's injury. Cross-reference F610 for failure to investigate an allegation of abuse related to an injury of unknown origin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to ensure incidents of potential abuse were thoroughly investigated for one (#1) of three residents out of 16 sample residents. Specifically, the facility failed to ensure an allegation of physical abuse, reported following the discovery of an injury of unknown origin, a bite wound, was thoroughly investigated and that the resident was monitored to prevent the possibility of a repeated instance. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, revised September 2022, was received from the director of nursing (DON) on 6/14/24 at 10:30 a.m. The policy documented in pertinent part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of property are reported to the local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect or injury of unknown source is suspected, the suspicion must be reported to the administrator and to other officials according to state law. -Upon receiving any allegation of abuse, neglect or an injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of residents. -All allegations are thoroughly investigated. The Investigation Injuries policy, revised December 2016, was received from the DON on 6/14/24 at 10:30 a.m. The policy documented in pertinent part, The administrator will ensure that all injuries are investigated. Documentation shall include information relevant to risk factors and conditions that could cause or predispose someone to similar signs and symptoms. Injury of unknown source is defined as an injury that meets both the following conditions: -The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and, -The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries at one particular point in time or the incident of the injuries over time. If an incident is suspected a nurse or nurse supervisor will complete a facility-approved accident/incident form. The form will be disseminated to the appropriate individuals, for example, the administrator and director of nursing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Abuse, Neglect, Exploitation or Misappropriation - prevention program policy, revised April 2021, was received from the DON on 6/14/24 at 10:30 a.m. The policy documented in pertinent part, Residents have the right to be free from abuse. II. Resident #1 A. Resident status Resident #1, age 76, was admitted on [DATE] and discharged to another facility on 5/5/24 According to the May 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia with behavioral disturbance and chronic kidney disease. According to the 3/9/24 minimum data set (MDS) assessment, the resident had severe cognitive impairments and was not able to complete the brief interview for mental status (BIMS) exam. Staff assessment of the resident revealed the resident usually understood others but had difficulty communicating some words or finishing thoughts but was able to communicate when prompted or given time; however, the resident missed some parts or intent of conversations. The resident had short and long-term memory problems and had moderately impaired cognitive skills for daily decision making for which the resident required cues and staff supervision. The resident wandered but did not display aggressive behaviors towards self or others. B. Resident representative interview Resident #1's representative was interviewed on 6/13/24 at 6:13 p.m. The representative said she was at the facility every day to visit with Resident #1. She said on the morning of 4/9/24 she received a call from Resident #1's hospice nurse asking if she knew about a bite mark on the top of Resident #1's wrist. The representative said that was the first time she was made aware that there was a bite mark on Resident #1's hand. The representative said she was at the facility the day prior (4/8/24) at lunchtime and the resident did not have the bite mark on his arm at that time so the injury had to have happened sometime after she left the faciity on [DATE] and the morning of 4/9/24. The representative said she went to the facility to find out what happened and observed the bite wound on Resident #1's arm. The representative said she talked to the staff on duty and no one knew that the resident had a bite wound and nobody could reasonably explain how the bite happened. The representative said she took a picture of the resident's wound to show the facility administration. The representative said the bite wound was on the top side of the resident's forearm, starting at the wrist, in a vertical straight up and down direction. She said there were several teeth marks that broke the skin on top of his wrist just above the wrist joint on the forearm. She said the reddened open wounds had started to scab over. She said there was bruising on the resident's arm approximately two inches from the crescent-shaped teeth impressions with broken skin and mild bruising. She said the bite wound was vertical, or straight up and down, along the arm and not at an angle along the side of the resident's arm or on the top and bottom of the arm, which would have been more typical if the resident had bitten himself. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The representative said she spoke to licensed practical nurse (LPN) #2, who was Resident #1's nurse and was familiar with him. She said she asked LPN #2 to look at the resident's arm. She said LPN #2 examined the resident and said she thought he bit himself. The representative said she told LPN #2 that she did not believe the resident could have bitten himself due to the placement of the bite being so straight up and down on the top of the Resident's arm. The representative said, as far as she was aware, LPN #2 took no other action to address the nature of the bite on Resident #1's arm. The representative said after speaking to LPN #2 she spoke to LPN #3, who was the memory care unit manager. She said LPN #3 said she was unaware of the bite mark on Resident #1 but would look into the matter. The representative said she never heard anything further from facility staff about how Resident #1 got the bite mark on his hand. The representative said she was concerned for Resident #1's safety. C. Record review -A review of Resident #1's electronic medical record (EMR) revealed no documentation from the facility staff about Resident #1 having a bite mark on the top of his left hand on or around 4/9/24. -Additionally, there was no documentation to indicate that Resident #1 had a history of self-injurious behaviors or self-biting behaviors. -A review of the resident's medication administration record (MAR) revealed the only behaviors documented on 4/8/24 and 4/9/24 were restlessness and pacing. A review of hospice notes revealed the hospice nurse was notified that the resident had a bite mark on the top of his left hand that was reported by the hospice certified nurse aide (CNA) on 4/9/24. The hospice notes documented the following: A hospice nurse note, dated 4/9/24, documented the nurse was notified by the hospice CNA that Resident #1 had what appears to be a bite mark on his left hand. The hospice nurse contacted the resident's representative to see if she was at the facility or had already been informed. The resident's representative was unaware of the bite mark and told the hospice nurse she was going to the facility to find out what was going on. Later that day (4/9/24) the memory care unit manager (LPN #3) called the hospice nurse and was upset that the wife knew of the resident's injury prior to the facility staff assessing the new wound. -However, LPN #3 denied knowing anything about Resident #1 having a bite mark on his person when interviewed (see LPN #3 interview below). A hospice nurse note dated 4/11/24 documented a facility CNA stated the resident was up all night and very tired. The resident had an injury, a presumed bite, to the left hand with no signs or symptoms of infection noted. A hospice nurse note dated 4/18//24 documented the resident had scabs to his left hand from an apparent bite which was healing. The hospice nurse collaborated with the facility nurse (LPN #1) and updated the resident's binder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, LPN #1 denied knowing anything about Resident #1 having a bite mark on his person when interviewed (see LPN #1 interview below). D. Staff interview LPN #2 was interviewed on 6/12/24 at 1:30 p.m. LPN #2 said she remembered Resident #1 but said she did not work with him a lot. She said the resident's representative did mention that he had a bite wound but she was not his nurse and she did not assess him at that time or see the bite wound. She said he did have scratches on his arm. -However, a review of Resident #1's MAR revealed LPN #2 was the nurse who was administering medications and documented behavior monitoring for Resident #1 on almost every shift in April 2024, including 4/9/24, the day the bite wound was discovered. Registered nurse (RN) #1 was interviewed on 6/12/24 at 1:33 p.m. RN #1 said she was new to the unit and was not working in her position when Resident #1 was in the facility. RN #1 said there were a lot of aggressive residents needing monitoring and redirection in order to prevent resident to resident altercations. LPN #3 was interviewed on 6/12/24 at 1:36 p.m. LPN #3 said she had no knowledge of the resident having a bite mark on his arm. She said she was only aware that he had some scratches on his person which she attributed to his wandering. She said the resident was not aggressive toward others but did wander and needed a lot of redirection to stay in areas where staff could monitor him. -However, the resident's representative said she spoke directly to LPN #3 (see representative interview above) to report the bite marks and an injury of unknown origin and asked for information on how the bite occurred. -Additionally, the hospice registered nurse (HRN) documented in the progress notes (see record review above) and confirmed in an interview (see interview below) that she spoke to LPN #3 about the bite wound on Resident #1's left arm. The memory care unit social services assistant (SSA) was interviewed on 6/12/24 at 1:38 p.m. The SSA said Resident #1's representative mentioned that Resident #1 had a bite mark on his hand The SSA said she did not see the bite mark and the resident's representative had made no further inquiry about the nature of the bite mark. The SSA said Resident #1 was not aggressive towards other residents but he wandered into other resident's rooms which startled some residents and was bothersome to some of the residents in the unit. She said, for that reason, staff were required to keep an eye on Resident #1 and provide continuous redirection when he was wandering. The HRN was interviewed on 6/12/24 at 2:16 p.m. The HRN said the resident's hospice CNA called her on the morning of 4/9/24 to report that the resident had a wound on the top of his left forearm that looked like a bite mark. The HRN said the hospice CNA reported to her that the facility staff were unaware of how the resident got the wound. The HRN said she called the facility before calling the resident's representative, but had to leave a voice message when the memory care unit manager (LPN #3) did not answer the phone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The HRN said when she called the resident's representative to see if she was at the facility or had knowledge of what happened to Resident #1, the resident's representative did not even know the resident had a bite mark wound on his person. The HRN said about 30 minutes after talking to the resident's representative, she received a call from LPN #3 scolding her for not calling the facility first. The HRN said LPN #3 said she had no awareness of a bite wound on Resident #1 and then in the same conversation said the resident bit himself. The HRN said she assessed the resident's wound on 4/11/24, cleaned the wound and bandaged it. The HRN said the wound on Resident #1's upper forearm at the wrist was definitely teeth impression marks. She said the bite was in a pattern of a full set of upper teeth and partial bottom teeth and it was in a placement pattern that was unlikely that he would have done it himself. The HRN said she observed the resident to have several bruises, scratches and other injuries of unknown origin over the next several weeks with no explanation of how he was injured. The HRN said she had concerns because Resident #1 was known to wander into other resident's rooms and was often injured as a result of some other residents being upset over his wandering behaviors. The HRN said there were a lot of residents on the unit who were physically aggressive toward other residents Cross-reference F600 for failure to prevent resident to resident altercations. The DON was interviewed on 6/13/24 at 11:05 a.m. The DON said the facility did not have an investigation for the resident's bite wound and it was not reported to the State oversight office as an injury of unknown origin. The DON said she had heard about the allegation that Resident #1 had a bite mark on his arm so she asked one of the facility nurses to look at his arm. The DON said she did not examine the resident herself and could not remember which nurse she asked to look at the resident's arm but she said remembered the nurse reported the resident did not have a bite wound. The DON said she did not know why there was no documentation of the assessment of Resident #1 done by the nurse but said she would try to find out which nurse assessed the resident and look to see if the facility had any documentation of the allegation and the assessment of the resident. -The DON did not provide any additional evidence to indicate the allegation that Resident #1 sustained a bite wound of unknown origin was investigated or that the nursing staff assessed and monitored the resident's injury. Cross-referenced to F609 failure to report a suspicious injury of unknown origin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 was interviewed on 6/14/24 at p.m. LPN #1 said Resident #1 frequently wandered the unit and needed staff redirection to ensure his safety. She said his wandering did not bother other residents. LPN #1 said he was working on the secured unit on 4/9/24 and he did see a circular red mark on Resident #1's arm but assumed he had bumped into something due to his constant wandering. LPN #1 said he did not assess the resident's injury because he was not the resident's assigned nurse. He said even though the resident lived on the 500 unit he was assigned to the care of a nurse who worked the 400 unit which was just on the other side of the locked unit doors. LPN #1 said the 400 unit would cross the threshold of the secured doors to administer medication, provide treatments, and other types of nursing care services to Resident #1 and a couple of other residents. E. Facility follow-up On 6/14/24 at 2:43 p.m. the DON provided an employee counseling form dated 6/14/24. The counseling form read in pertinent part, Employee name: LPN #3. Verbal warning. Nature of infraction: You failed to complete a risk management for a bite that occurred on your unit. Corrective action: Review of policy on reporting, and verbal education on the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 41032 Based on record review and staff interviews, the facility failed to have a written transfer agreement with one or more hospitals approved for participation under Medicare and Medicaid programs to reasonably ensure residents would be transferred from the facility to a hospital, and assured of timely admission to the hospital when transfer was medically appropriate. Specifically, the facility failed to ensure a written agreement was in effect with one local area hospital. Findings include: I. Record review A request was made to the director of nursing (DON) and corporate nurse consultant (CNC) #1 on 6/13/24 at 4:27 p.m., for the facility's hospital transfer agreement. -The facility was unable to provide a written agreement for the one area hospital. II. Interview The interim nursing home administrator (INHA) and CNC #1 and CNC #2 were interviewed together on 6/14/24 at 3:55 p.m. The INHA said the facility did not have a hospital transfer agreement. The INHA said no area hospitals would provide the facility with a transfer agreement because the hospitals took residents based on the hospital's availability to accept patients. She said since patients were diverted to the closest available hospital a transfer agreement was not necessary.