

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/07/2025
NAME OF PROVIDER OR SUPPLIER  Skylake Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48412</p> <p>Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Ensure staff wore the appropriate personal protective equipment (PPE) when providing direct care to a resident who was on enhanced barrier precautions (EBP); and,</li> <li>-Follow appropriate infection control measures during wound care.</li> </ul> <p>Findings include:</p> <p>I. PPE failures</p> <p>A. Facility policy and procedure</p> <p>The Enhanced Barrier Precautions policy, undated, was provided by the director of nursing (DON) on 5/7/25 at 9:20 a.m. It read in pertinent part,</p> <p>Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a multi-drug resistant organism (MDRO) as well as those at increased risk of MDRO acquisition.</p> <p>High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting; device care or use and wound care.</p> <p>B. Observations</p> <p>On 5/6/25 at 10:26 a.m. an unidentified certified nurse aide (CNA) changed and repositioned Resident #1. The unidentified CNA was wearing gloves, but did not have a gown on. Resident #1's door had a sign on it that indicated Resident #1 was on r EBP.</p> <p>The unidentified CNA failed to wear a gown when providing direct care to Resident #1.</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/7/25 at 9:10 a.m. licensed practical nurse (LPN) #1 and LPN #2 provided wound care and repositioned Resident #1 with gloves on.</p> <p>-LPN #1 and LPN #2 failed to put on a gown when providing direct care to Resident #1.</p> <p>C. Staff interviews</p> <p>The DON was interviewed on 5/7/25 at 10:40 a.m. The DON said when a staff member was providing direct care to a resident who was on EBP, the staff member needed to wear gloves and a gown.</p> <p>II. Wound care failures</p> <p>A. Observations</p> <p>LPN #1 and LPN #2 were observed performing wound care for Resident #1 on 5/7/25 at 9:10 a.m. The following was observed:</p> <p>LPN #2 took a pair of scissors out of her pocket and cut a piece of calcium alginate (wound dressing) and returned the scissors to her pocket.</p> <p>-LPN #2 did not sanitize the scissors prior to cutting the piece of calcium alginate.</p> <p>LPN #1 pulled a retractable tape measure out of his fanny pack and measured an open area on Resident #1's buttock that had blood on it. He touched Resident #1's skin with the tape measure. He then pushed a button which caused the tape measure to retract and returned it to his fanny pack.</p> <p>-LPN #1 did not sanitize the retractable tape measure before or after using it.</p> <p>LPN #2 retrieved wound care supplies and placed them directly on Resident #1's nightstand. Resident #1's nightstand had Resident #1's personal items on it.</p> <p>-LPN #2 did not have a clean working surface before completing wound care.</p> <p>C. Staff interviews</p> <p>The wound care nurse (WCN) was interviewed on 5/7/25 at 10:12 a.m. The WCN said each resident had their own wound care bag, which included scissors, dressings and wound cleansers to prevent the spread of infections. The WCN said a clean work area was important for infection control and preventing wound contamination.</p> <p>The DON was interviewed on 5/7/25 at 10:40 a.m. The DON said each resident had a bag of wound care supplies that were specific to the resident and the scissors needed to be in the bag for the resident to prevent cross-contamination. The DON was interviewed on 5/7/25 at 10:40 a.m. The DON said the nurse needed to place the wound care supplies on a clean area. The DON said LPN #2 should have placed the materials on a disposable chuck (absorbent pads).</p>		