

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 12/01/2025
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)		
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on record review and interviews, the facility failed to ensure money from personal funds accounts was managed accurately for two (#175 and #45) out of five residents reviewed for personal funds accounts out of 71 sample residents. Specifically, the facility failed to notify Resident #175 and Resident #45, who were Medicaid funded, or their legal representative when the resident's personal funds account reached \$200.00 less than the eligibility resource limit. Findings include: I. Resident accounts A. Resident #175 Resident #175 had an account balance of \$1,915.07. -There was no documentation the facility had notified Resident #175 or her legal representative when her personal funds account reached \$200 less than the eligibility resource limit. B. Resident #45 Resident #45 had an account balance of \$1,892.06. -There was no documentation the facility had notified Resident #45 or her legal representative when her personal funds account reached \$200 less than the eligibility resource limit. II. Staff interviews The nursing home administrator (NHA) was interviewed on 9/23/25 at 1:15 p.m. The NHA said the business office manager (BOM) was out of the office. The NHA said there was some confusion as to what the allotted limit for Medicaid funded residents was. The NHA said the facility was going to reach out to the residents' representatives to spend down the funds.		

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