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	03/04/2026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide choices for preference of bathing schedule for one (#1) of three residents reviewed for self-determination out of eight sample residents.Specifically, the facility failed to ensure Resident #1 received showers consistent with her preferences.Findings include:I. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE], readmitted on [DATE] and discharged to the hospital on 1/28/26. According to the January 2026 computerized physician orders (CPO), diagnoses included severe sepsis with septic shock (severe infection that causes organ failure), pneumonia, major depressive disorder, and weakness. The 1/22/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required set-up or clean-up assistance with eating and substantial to maximal assistance with oral hygiene, toileting hygiene and dressing. -The MDS assessment revealed that bathing was documented as not applicable for assistance. B. Resident's representative interviewResident #1's representative was interviewed on 3/3/26 at 1:26 p.m. The representative said Resident #1 told her staff were busy and were not providing her with showers. The representative said Resident #1 requested a shower the week after she was admitted to the facility (week of 1/18/26) and staff did not provide a shower to her. The representative said Resident #1 called her and said staff did not give her a shower and that was how she became aware of the concern. The representative said she had observed Resident #1 wearing the same clothing on multiple occasions, which led her to believe Resident #1 was not receiving showers. The representative said when she visited Resident #1, the resident had a personal female odor. The representative said Resident #1 appeared upset and expressed a desire to be clean. The representative said she asked the director of nursing (DON) for documentation showing completion of the showers for Resident #1, but the facility could not provide her with documentation. C. Record reviewResident #1's activities of daily living (ADL) care plan, initiated 1/16/26, documented the resident needed partial to substantial assistance for bathing or showering.-However, the care plan failed to include the resident's preferences or specific days for showers. A review of the certified nurse aide (CNA) bathing task documentation for Resident #1, from 1/16/26 through 1/28/26, revealed no documentation to indicate showers were provided to the resident during her stay at the facility.A review of Resident #1's electronic medical record (EMR) revealed the resident's shower preference assessment was not completed upon the resident's admission to the facility.II. Staff interviewsCNA #2 was interviewed on 3/4/26 at 11:14 a.m. CNA #2 said the residents' shower schedules were listed at the nurses' station and indicated how often residents were to receive showers. CNA #2 said residents were scheduled to receive showers three times each week and residents could choose a preference for morning or evening showers.CNA #2 said Resident #1 was scheduled to receive showers on Monday, Wednesday and Friday. CNA #2 said the shower schedule was communicated to staff during shift change and staff reviewed the shower schedule sheet. CNA #2 said if a resident refused a shower, staff would ask the resident three times if they wanted a shower and then documented the refusal in the resident's EMR and notified the nurse. CNA #2 said (continued on next page)

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

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 often prepared for therapy during the day shift and after therapy appeared exhausted and sometimes refused showers. CNA #2 said Resident #1 received therapy five times per week and sometimes refused showers due to fatigue. CNA #2 said refusals were documented and communicated to the night shift if the resident refused a shower during the morning shift. CNA #2 said if a shower was missed and staff had time the next day, they would attempt to provide the refused shower to the resident. CNA #2 said if staff were busy, the resident would not receive a shower until their next scheduled shower.Licensed practical nurse (LPN) #1 was interviewed on 3/4/26 at 11:30 a.m. LPN #1 said if a resident refused a shower, she would ask the CNA to offer the shower again and if the resident refused a third time, the nurse would document the refusal in a progress note. LPN #1 said the staff would contact the resident's family to see if the family could encourage the resident to accept the shower. LPN #1 said during shift change, staff communicated with the oncoming shift regarding showers that were not completed. LPN #1 said if a shower was missed, staff would attempt to provide the shower the next day and Saturdays were used as a make-up day for showers that were previously refused.The director of nursing (DON) was interviewed on 3/4/26 at 2:32 p.m. The DON said residents were supposed to be offered showers two times per week unless the resident wanted more frequent showers. The DON said a preference evaluation was completed as part of the admission packet and new admissions were to be offered a shower the day after admission. The DON said staff said they offered showers to Resident #1, but they forgot to document the offers or resident refusals.The DON said the facility completed shower audits five times per week to ensure residents were offered showers and to verify refusals were documented. The DON said if a shower log showed no documented showers during a resident's stay, the facility would investigate which staff members worked during that time and determine whether showers were offered and whether the staff completed documentation about the showers.The DON said she was not aware of any concerns or complaints from the resident or family regarding bathing while Resident #1 was at the facility. The DON said she became aware of the concern after Resident #1 had discharged from the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of three residents reviewed for accidents out of eight sample residents received adequate supervision to prevent risk for accident hazards.Specifically, the facility failed to ensure safe assistance was provided by staff during incontinence care for Resident #1, which resulted in the resident sustaining a fall with minor injuries when she rolled out of bed during the care.Findings include: I. Facility policy and procedureThe Falls - Clinical Protocol policy, revised March 2018, was provided by the director of nursing (DON) on 3/4/26 at 3:04 p.m. It read in pertinent part, The physician will help identify individuals with a history of falls and risk factors for falling. Staff will ask the resident and the caregiver or family about a history of falling. The staff and physician will document in the medical record a history of one or more recent falls. The nurse shall assess and document or report vital signs, recent injury, especially fracture or head injury, musculoskeletal function observing for change in normal range of motion and weight bearing, change in cognition or level of consciousness, neurological status and pain. The nurse will also assess the frequency and number of falls since the last physician visit, precipitating factors and details on how the fall occurred, all current medications especially those associated with dizziness or lethargy and all active diagnoses. II. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE], readmitted on [DATE] and discharged to the hospital on 1/28/26. According to the January 2026 computerized physician orders (CPO), diagnoses included severe sepsis with septic shock (severe infection that causes organ failure), pneumonia, major depressive disorder, and weakness. The 1/22/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required set-up or clean-up assistance with eating and substantial to maximal assistance with oral hygiene, toileting hygiene and dressing. The MDS assessment did not indicate the resident had a history of falls. B. Resident's representative interviewResident #1's representative was interviewed on 3/3/26 at 1:26 p.m. The representative said Resident #1 told her that during incontinence care, an unknown certified nurse aide (CNA) kept pushing her to roll over and she fell off the bed. The representative said a nurse entered the room and observed the CNA pulling Resident #1 off the floor by her right arm, even though she said she had pain in her right arm and told the CNA to stop. The representative said that Resident #1 was upset. Resident #1's representative said Resident #1 called her approximately 30 minutes after the fall on 1/23/26 and said she sustained injuries to her right shoulder. The representative said the resident's right shoulder had been hurting prior to the fall, but the fall made the pain worse because the CNA tried to pull her up by her right arm. The representative said every toe on the resident's right foot had abrasions or bruising and staff placed bandages on them.Resident #1's representative said later that night, on 1/23/26, the facility called and said Resident #1 had a fall and was fine and they wanted to notify her. The representative said the facility did not inform her that Resident #1 sustained injuries.C. Record reviewThe activities of daily living (ADL) care plan, initiated 1/16/26, revealed Resident #1 had a self-care performance deficit related to severe septic shock from pneumonia and needed staff assistance with care. -However, the bed mobility intervention did not identify the level of assistance required or the number of staff needed.Review of Resident #1's fall care plan, initiated 1/16/26 and revised 1/28/26, revealed the resident was at risk for falls related to respiratory failure, chronic obstructive pulmonary disease (COPD) and chronic pain. Pertinent interventions included one-on-one staff education, ensuring all items were in reach while the resident was in bed or her chair, anticipating and meeting the resident's needs, keeping the resident's bed at transfer height, physical therapy evaluate and treat as ordered and two staff members to provide incontinence care. A fall risk assessment, dated 1/16/26, revealed the resident was a high fall risk.A fall investigation report, dated 1/23/26 at 8:30 p.m., revealed a CNA was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	providing incontinence care to Resident #1 when the resident rolled out of bed, landing on her bilateral lower extremities. No injuries were observed at the time of the fall. The resident said her pain was 4 out of 10 in her right shoulder. The nurse observed five skin tears to Resident #1's toes and a right knee abrasion. An IDT (interdisciplinary team) progress note, dated 1/27/26 at 3:37 p.m., revealed Resident #1 lifted her right leg and her weight shifted while she was being provided incontinence care. Resident #1 then rolled left and slid out of bed onto the floor, landing on her knees. Resident #1 had no new skin impairments as a result of the fall. The interventions included one-on-one staff education and two staff members were to perform incontinence care for the resident. -Review of Resident #1's electronic medical record (EMR) revealed there were no nursing progress notes related to Resident #1's fall on 1/23/26. III. Staff interviewsCNA #2 was interviewed on 3/4/26 at 12:55 p.m. CNA #2 said staff determined how to safely turn and reposition a resident in bed based on the resident's ability to assist with movement. CNA #2 said staff reviewed the Kardex (a comprehensive directive tool for care), care plan and hospital report information, and would ask the nurse, another CNA familiar with the resident or the resident about their ability if staff were unfamiliar with the resident or if the resident was a new admission to the facility. CNA #2 said the number of staff assisting with repositioning, bed mobility and incontinence care varied, depending on the resident's needs. CNA #2 said staff determined whether one or two staff members were required based on the resident's level of assistance. CNA #2 said during Resident #1's initial admission to the facility (7/14/25), the resident required two-person assistance but later progressed to needing only one-person assistance. CNA #2 said during the resident's second admission to the facility (1/16/26), Resident #1 required two-person assistance for bed mobility. CNA #2 said she did not know whether Resident #1 had one or two person assistance on the night of the incident (1/23/26). CNA #2 said staff were aware Resident #1 was considered a fall risk and used a wheelchair. CNA #2 said staff did not have concerns that the resident could slide off the bed while being turned during care. Registered nurse (RN) #1 was interviewed on 3/4/26 at 1:08 p.m. RN #1 said staff reviewed the care plan and Kardex to determine whether a resident required one or two-person assistance for bed mobility or repositioning. RN #1 said if the resident was newly admitted or readmitted to the facility, staff reviewed hospital records and physical therapy notes from the hospital. RN #1 said prior to the fall on 1/23/26, Resident #1 required partial to moderate assistance with turning during incontinence care and this meant the resident was able to assist with care. RN #1 said fall interventions in place prior to the fall included nonskid footwear, the call light within reach and encouragement for the resident to use the call light as needed. RN #1 said she did not find any interventions in the care plan specifically related to bed mobility and repositioning. RN #1 said staff were informed about the resident's fall risk and required assistance through the falling staff program, which placed a star outside the resident's door to indicate fall risk. RN #1 said staff additionally reviewed the Kardex and EMR documentation. RN #1 said after the fall occurred on 1/23/26, Resident #1's care instructions were updated to include the resident required two-person assistance for incontinence care. RN #1 said prior to the fall, Resident #1 was considered a high fall risk. The DON was interviewed on 3/4/26 at 2:32 p.m. The DON said based on Resident #1's medical condition, level of weakness and diagnoses, the resident required one-person assistance for turning in bed prior to the resident's fall on 1/23/26. The DON said the level of assistance required for a resident was identified in the residents' care plans.The DON said Resident #1 had weakness, which increased her risk for falling. The DON aid staff assessed the resident's needs for assistance primarily based on information reported by staff working on the floor and through ongoing assessment of the resident's condition. The DON said staff received education to use the mechanical lifts when appropriate rather than lifting residents manually. The DON said after the fall on 1/23/26, Resident #1 sustained abrasions to the right knee and toes. The DON said following the fall, the resident's care plan was updated to require two-person assistance for during the resident's incontinence care and repositioning. The DON said written education was provided to staff indicating Resident #1 required two-person assistance.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure food served accommodated residents' allergies and intolerances for one (#1) of three residents reviewed out of eight sample residents.Specifically, the facility failed to ensure Resident #1 was not served food the resident was allergic to, despite the resident having a documented food allergy.Findings include:I. Facility policy and procedureThe Food Allergies and Intolerances policy, revised August 2017, was provided by the director of nursing (DON) on 3/4/26 at 3:04 p.m. It revealed in pertinent part, Residents with food allergies and or intolerances are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident exposure to the allergen. Residents are assessed for a history of food allergies and intolerances upon admission and as part of the comprehensive assessment. All reported food allergies and intolerances are documented into the resident care plan. Residents with food intolerances and allergies are offered appropriate substitutions for foods that they cannot eat.II. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE], readmitted on [DATE] and discharged to the hospital on 1/28/26. According to the January 2026 computerized physician orders (CPO), diagnoses included severe sepsis with septic shock, pneumonia, major depressive disorder, and weakness. The 1/22/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required set-up or clean-up assistance with eating and substantial to maximal assistance with oral hygiene, toileting hygiene and dressing.B. Resident's representative interviewResident #1's representative was interviewed on 3/3/26 at 1:26 p.m. The representative said the facility had documented that Resident #1 was allergic to pineapple and the allergy was included on the resident's meal ticket. The representative said the facility still served pineapple to Resident #1, despite documentation indicating the resident was allergic to pineapple. The representative said Resident #1 ate a few pieces of pineapple before realizing it was pineapple. The representative said staff gave Resident #1 medication to prevent any allergic reactions after the resident ate the pineapple, and no reaction was noted. The representative said Resident #1 was upset and did not understand how the pineapple was served despite the allergy being documented in the resident's medical record and on her meal ticket the certified nurse aides (CNA) had access to when delivering the resident's meal tray. C. Record reviewReview of Resident #1's comprehensive care plan, initiated 1/16/26, revealed Resident #1 had allergies to pineapple and wool.The care plan report, initiated 1/16/26 and revised 1/26/26, identified Resident #1 as having an allergy to pineapple and included a nutrition intervention for staff to honor the resident's food preferences.-The care plan did not reveal the resident's food likes and dislikes.The nursing progress note, dated 1/21/26 at 9:10 p.m., revealed the resident had pineapple on her dinner tray. The progress note documented the resident had a pineapple allergy and ate two pieces of the pineapple. The progress note documented staff notified the on-call physician orders were obtained to give the resident Benadryl (antihistamine medication). The progress note documented staff noted no adverse reactions after the incident and the resident's vital signs were stable.The progress note, dated 1/22/26, documented a physician's order for Benadryl (diphenhydramine HCl) 25 milligrams (mg) capsule with directions to give 25 mg by mouth every six hours as needed for allergy. Review of the facility's Quality Assurance and Performance Improvement (QAPI) root cause analysis, dated 1/22/26, revealed Resident #1 was served pineapple on her dinner meal tray on 1/21/26, despite having a documented pineapple allergy. The review revealed the resident ingested two pieces of pineapple before staff identified the error and removed the food from the tray. Nursing management and the physician were notified and diphenhydramine (Benadryl) was ordered as needed. The resident was monitored and no allergic reaction or negative outcome was reported. Review of the QAPI root (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cause analysis revealed the dietary aide (DA) serving the residents' food on 1/21/26 did not note the resident's pineapple allergy on the meal card and pineapple was placed on the resident's tray as a dessert. The review further revealed the CNA identified the pineapple on the tray and removed it after the resident had already ingested two pieces of the pineapple.Review of the facility's corrective action plan revealed dietary staff were educated to verify that foods served matched the meal cards with attention to residents' documented allergies. The document additionally revealed nursing staff were educated to verify that the food served matched the resident's meal card. The plan documented residents' allergies would be clearly listed on meal cards to assist staff when passing meal trays.Review of the facility's staff education regarding meal verification and allergies revealed staff were educated to verify each resident's meal card accurately and ensured it reflected the resident's current diet order, texture and restrictions. The education documented staff should check meal cards daily and whenever there was a diet change for a resident. The staff education document revealed the education reviewed the process for clearly identifying residents' food allergies on the residents' meal cards and staff should immediately report any missing or incorrect allergy information to nursing and dietary services. The education further documented staff should confirm the meal being served matched the resident's meal card and should not provide food items that conflicted with physician ordered diets or documented allergies. Review of the in-service sign in sheet, dated 1/27/26, revealed dietary staff attended the education regarding meal card verification and accuracy.-However, the facility failed to ensure the corrective action was sustained (see resident council notes below). Review of the resident council meeting notes, dated 1/29/26, revealed residents reported meal service concerns. One resident communicated that CNAs blamed the kitchen for meal mistakes and did not correct the issue when errors occurred. Residents also communicated that some CNAs did not ask residents for their meal choices.Review of the resident council meeting notes, dated 2/26/26, revealed a resident communicated that meal tickets were not being followed correctly by CNAs on the Evergreen unit.III. Staff interviewsThe dietary manager (DM) was interviewed on 3/4/26 at 10:21 a.m. The DM said resident allergies were identified through the meal tickets printed by either the DS or the dietitian. The DM said the meal tickets included the residents' food allergies and the allergies were highlighted. The DM said the dDAs verified the meal tickets before the meal cart left the kitchen and the CNAs on the floor also checked the tickets.The DM said in the incident involving Resident #1's pineapple allergy, the DA did not review the resident's meal ticket correctly and did not pay attention to the resident's documented food allergy because staff were trying to serve trays quickly.DA #1 was interviewed on 3/4/26 at 10:31 a.m. DA #1 said residents' food allergies were identified by reviewing the meal tickets. DA #1 said the meal tickets listed diet textures such as soft and bite-sized diets and identified residents with allergies. DA #1 said residents' food allergies were highlighted in yellow so staff knew what to look for when preparing trays.DA #1 said if a food item on a tray was something a resident was allergic to, staff would remove the item and provide an alternative food, such as applesauce instead of pineapple. DA #1 said if a resident's meal tray had already been prepared with the incorrect food item, staff would discard the tray and prepare a new meal tray for the resident with the correct substitute food item.Cook (CK) #1 was interviewed on 3/4/26 at 10:36 a.m. CK #1 said residents' food allergies were identified by reviewing the meal tickets before giving the tickets to the DA. CK #1 said kitchen staff reviewed the meal tickets thoroughly to ensure residents did not receive foods they were not allowed to have.CK #1 said if a food item on a tray was something a resident was allergic to, staff ensured the item was not served to the resident and removed the tray. CK #1 said once meal tickets were printed and the DA highlighted residents' allergies, staff ensured residents did not receive foods that they were not allowed to have. CK #1 said the DAs checked meal trays before they left the kitchen.The registered dietitian (RD) was interviewed on 3/4/26 at 10:44 a.m. The RD said the residents' food allergies were documented at the time of the resident's initial admission and remained documented during subsequent admissions. The RD said the facility used a software program to track residents' food allergies, preferences and diet orders. The RD said the software (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	program integrated with the residents' electronic medical records (EMR), and diet orders and allergies were communicated to the kitchen through that system and updated as needed.The RD said residents' food allergy information was communicated to kitchen staff and nursing staff through the residents' meal cards. The RD said the CKs prepared the entree, passed it to the DAs and the DAs placed the dessert on the meal tray and the meal tray on the meal delivery cart. The RD said floor staff were expected to review and verify the residents' meal cards before serving the meal trays to the residents.The RD said the incident regarding Resident #1 being served a food she was allergic to was discussed in a clinical meeting the next day following the incident (1/22/26) and education was provided to staff on 1/27/26. -However, education was not provided to staff until five days after the IDT discussed the incident and six days after the incident with Resident #1 occurred.CNA #1 was interviewed on 3/4/26 at 11:01 a.m. CNA #1 said staff identified foods a resident should not receive due to allergies or diet restrictions by reviewing the resident's meal ticket. CNA #1 said staff checked the meal tickets to verify the correct foods were served to residents. CNA #1 said everyone in the kitchen and on the floor passing trays checked the meal tickets. CNA #1 said if a food item on the tray was something the resident may be allergic to, staff would take the tray back to the kitchen to obtain an alternative food item and reported the concern to the unit manager.Registered nurse (RN) #1 was interviewed on 3/4/26 at 11:08 a.m. RN #1 said a resident's allergies would be documented in the admission paperwork and would then be entered into their EMR. RN #1 said the allergy information would be written on the resident's meal tray ticket so dietary staff and nursing staff would be aware of the resident's allergies. RN #1 said each staff member was expected to review the meal ticket on each resident's tray to ensure residents did not receive foods they were allergic to. RN #1 said if staff identified an allergen on a resident's tray, staff removed the meal tray and obtained a new tray from the kitchen with an alternative food item.RN #1 said if a resident ingested a food item they were allergic to, staff removed the food, obtained the resident's vital signs and notified the physician for further orders. RN #1 said the incident would be documented in the resident's progress notes.The DON was interviewed on 3/4/26 at 2:32 p.m. The DON said the meal ticket system populated residents' diet orders and allergies and staff highlighted the allergy information. The DON said kitchen staff and nursing staff were expected to review the meal tickets to ensure residents did not receive foods they were allergic to. The DON said the facility was attempting to determine where the break in the system occurred related to Resident #1's pineapple allergy incident.The DON said after the incident with Resident #1 on 1/21/26, the facility implemented audits and worked with the kitchen manager to ensure an additional staff member reviewed meal trays before they left the kitchen.The DON said nursing staff verified that the meals being delivered matched the resident's diet orders and allergy information by comparing the meal cards with the meal trays before serving the meal to the residents.The DON said staff compliance was monitored through ongoing audits and follow-up education with staff to ensure the process was followed.-However, review of resident council meeting notes revealed residents still had concerns with CNAs not following meal tickets on 2/26/26 (see record review above).