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	05/11/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, record review and interviews, the facility failed to ensure four (#17, #6, #7 and #5) of seven residents reviewed for abuse out of 14 sample residents were kept free from abuse.Specifically, the facility failed to:-Prevent an incident of physical abuse between Resident #6 and Resident #17;-Prevent an incident of physical abuse between Resident #6 and Resident #7; and,-Protect Resident #5 from physical abuse by Resident #6. Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy and procedure, revised April 2021, was provided by regional director of clinical services #1 on 5/11/26 at 5:04 p.m. It read in pertinent part, The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support objectives including providing staff orientation and training which included topics such as handling verbally or physically aggressive resident behavior.II. Incident of physical abuse by Resident #17 towards Resident #6 on 3/30/26A. Facility investigationThe facility investigation, dated 3/30/26, was provided by the nursing home administrator (NHA)on 5/11/26 at 9:00 a.m. The investigation revealed the following:On 3/30/26 at 1:30 p.m. Resident #17 was sitting in the hallway in her wheelchair yelling about having her bed made. Resident #6 walked by Resident #17, and Resident #17 began screaming at him and telling him to just hit her already. Resident #6 stepped up to Resident #17 and she swung her arm at his stomach to hit him. Resident #6 grabbed Resident #17 by the neck/shoulder area to attempt to stop her from hitting him. The residents were separated by staff, de-escalated, assessed and placed on 15-minute checks.The investigation documented Resident #6 seemed to escalate with loud noises. Resident #6's representative said she would purchase headphones for him. Resident #6's physician was notified and medication adjustments related to the resident's anxiety and agitation.An interview with registered nurse (RN) #3, dated 3/30/26 at 2:00 p.m., revealed the nursing staff member had witnessed the altercation. The interview revealed Resident #17 was yelling at Resident #6, then told Resident #6 to just hit her and to do it already. Resident #6 stepped up to her and Resident #17 hit him in the stomach. Resident #6 then grabbed Resident #17 by the back of the neck and told her I don't do that hitting (expletive). RN #3 said they then approached the residents and began to try to de-escalate both of them. Resident #6 let go of Resident #17 and walked away with a member of the social services staff. RN #3 said Resident #6 remained agitated and responsive to any loud noise or situation and was constantly redirected to attempt to de-escalate him. Resident #6's physician was aware and the nursing staff were charting the resident's behaviors.The investigation documented both Resident #17 and Resident #6 were interviewed but had no recollection of the event. Both residents did not display any signs or symptoms of behavioral changes following the event.The investigation documented Resident #6 had a history of becoming verbally aggressive toward other residents and staff members, including calling others names, using derogatory language or making verbally inappropriate or hostile statements. Resident #6 would often sundown and think he was at work and become irritated when staff did not follow his directions.The investigation documented Resident #17 had a history of behavior problems including being angry at her placement and using foul language. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #17 was hard of hearing which caused her to speak in a loud tone.The investigation unsubstantiated the allegation of abuse as there were no signs or symptoms noted from either resident that Resident #17 had made contact with Resident #6 or vice-versa. The residents' care plans were updated following the event.-However, physical abuse occurred due to Resident #17 hitting Resident #6 and Resident #6 grabbing Resident #17's neck, per the staff interview included in the facility investigation.B. Resident #61. Resident statusResident #6, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included dementia with agitation. The 2/5/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of one out of 15. The resident required partial to substantial assistance from staff for most activities of daily living (ADL).The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others.2. Resident's representative interviewResident #6's representative was interviewed on 5/11/26 at 10:15 a.m. The resident's representative said Resident #6 had dementia with aggression. The representative said the facility had handled Resident #6's aggression well and did so by calling the police and ambulances and trying to comfort the resident. The resident's representative said Resident #6 had been through hell and back, and said he had a lot of traumatic history and was reliving those traumatic moments due to his dementia. The representative said Resident #6's aggression was not predictable, and his triggers depended on his mood and surroundings. The resident's representative said Resident #6 could be comforted by using things like chocolate, coffee, or staff walking with him.3. Record reviewThe physical altercation care plan, revised 4/17/26, revealed Resident #6 was the victim of a physical altercation with another resident and documented that on 4/17/26 Resident #6 wandered into a female resident's room and was the victim of a physical altercation. Interventions included placing Resident #6 on 15-minute checks for the safety of himself and others, and keeping Resident #6 in high visibility areas when Resident #17 was nearby.The behavior care plan, revised 4/23/26, revealed Resident #6 had a behavior problem and was physically and verbally aggressive towards staff and other residents. Resident #6 was placed on one-to-one supervision for the safety of himself and others. Pertinent interventions included anticipating and meeting Resident #6's needs, administering medications as ordered, providing opportunities for positive interactions, keeping Resident #6 and Resident #5 separated, and monitoring behavior episodes and attempting to determine an underlying cause.The psychosocial-behavior care plan, revised 3/11/26, revealed Resident #6 exhibited or was at risk for behavioral symptoms due to his dementia. Resident #6 was attempting to forcefully open another resident's door and was not easily redirected. Resident #6 had a history of banging or punching his fist on objects including doors and walls. Resident #6 had a history of becoming physically aggressive toward staff members, and incidents included striking out, hitting, scratching and attempting to choke staff during redirection or care interactions. Resident #6 appeared to become more agitated at times when redirected by male staff members. Pertinent interventions included offering Resident #6 his favorite drinks including lemon-lime sodas or hot chocolate, reducing stimulation to the extent possible, observing and documenting changes in behavior, and using female staff to take lead during redirection or cares when possible.The psychosocial-trauma care plan, revised 2/10/26, revealed Resident #6 was at risk of emotional distress or decreased psychosocial well-being due to his history of combat or exposure to a warzone, history of fire, history of unwanted or uncomfortable sexual experiences and history of sudden, unexpected death of someone close to him. Resident #6's family had shared during his time in the army the resident was physically and sexually abused. Potential triggers included talking about Resident #6's mother and fire alarms. Pertinent interventions included attempting non-pharmacological approaches to reduce fears, observing for signs and symptoms of distress, and helping Resident #6 to identify triggers that prompted symptoms.The psychosocial-behavioral care plan, revised 5/6/26 (during the survey process), revealed Resident #6 exhibited or was at risk for behavioral symptoms due to his dementia. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6 had a history of becoming verbally and physically aggressive towards other residents and staff. Resident #6's behaviors included calling others inappropriate names, using derogatory language and making hostile statements. Resident #6 had also struck items such as doors or the medication cart when expressing frustration, and held his closed fist up to staff and residents and shaken it, indicating his intent to strike someone with a closed fist. Pertinent interventions included documenting and recording behavioral episodes, managing environmental factors to optimize comfort and reducing stimulation to the extent possible.The psychosocial-behavior care plan, revised 5/7/26 (during the survey process), revealed Resident #6 exhibited or was at risk for behavioral symptoms due to his dementia. Resident #6 had a history of experiencing sundowning in the early evening, during which episodes he believed he was at work and became verbally agitated as he said he had a lot of work to do and no one was helping him. Resident #6 also verbalized he thought people hated him, which contributed to his distress and increased his agitation. Pertinent interventions included voice or video-calling Resident #6's representative, providing one-to-one supervision and reducing stimulation to the extent possible.The psychosocial-grief care plan, initiated 5/6/26 (during the survey process), revealed Resident #6 had experienced the loss of both of his parents and was often emotional about his parents when sundowning. Pertinent interventions included supporting Resident #6's grief reactions and exploring coping mechanisms with the resident.The behavior/mood section of Resident #6's Kardex (a staff directive tool) was reviewed on 5/11/26 and revealed pertinent interventions including anticipating needs, voice or video-calling Resident #6's representative, using a night-light, observing for signs or symptoms of distress, offering a lemon-lime soda, and using hot chocolate to deescalate any behaviors the resident may be having.The behavior section of Resident #6's Kardex (a staff directive tool) was reviewed on 5/11/26 and revealed pertinent interventions including administering medications as ordered, attempting non-pharmacological techniques, using female staff to take lead when redirecting care tasks as Resident #6 appeared less reactive with female caregivers, offering the resident his favorite drinks including lemon-lime sodas or hot chocolate, using non-threatening body language, reducing stimulation to the extent possible, and contacting Resident #6's representative for comfort and support.Hospital discharge notes, dated 1/30/26 at 11:52 a.m., revealed Resident #6 was admitted to the hospital for increased agitation and the inability for his family to continue to care for the resident at home. Hospital follow-up recommendations documented ongoing adjustments to Resident #6's agitation medications may be needed.A progress note, dated 2/4/26 at 7:57 p.m., revealed Resident #6 was agitated when the nurse was giving medication to his roommate. Resident #6 said why the (expletive) are you in my room taking my (expletive). Resident #6 came out of his room and was cursing and hitting his hand into his other hand, following staff members around and trying to swing at staff. Multiple staff members attempted to redirect Resident #6 and reassure him no one was stealing anything from his room.A progress note, dated 2/5/26 at 6:57 p.m., revealed Resident #6 confronted a nurse at his computer at 6:00 p.m. that evening and started to become agitated. Resident #6 told the nurse he needed to tell him how to press the two buttons, which made no sense in context. Resident #6 then became very angry and slammed his fist on the desk. The nurse explained he did not understand Resident #6's request and asked him to remain calm, but as the nurse stood up to assist Resident #6 to his room, he became very angry and physically aggressive. Resident #6 started shouting and getting into the nurse's face. The nurse was able to calm the resident down and assist him to his room.A progress note, dated 2/7/26 at 9:13 p.m., revealed Resident #6 became agitated around 8:30 p.m. that evening and began yelling and using derogatory language towards the CNA on shift, demanding to know why he was in his room, asking to go outside and saying he needed a strong medication to calm down. As the CNA left Resident #6's room to inform the nurse, the resident got out of his bed and began punching and hitting his door loudly and displaying verbal and physical aggression.A progress note, dated 2/24/26 at 1:09 a.m., revealed Resident #6 had been pacing and accusing staff of stealing from him and lying to him about getting his stuff back. Resident #6 entered another resident's room and was promptly escorted back (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	out of the room by nursing staff. Resident #6 had not displayed any violent behavior yet but continued to pace up and down the unit. Resident #6 continued to state the staff had stolen from him and lied to him, and yelled expletives at the nursing staff.A progress note, dated 2/27/26 at 7:46 p.m., revealed Resident #6 was pacing and wandering. Resident #6 would approach staff or other residents in an angry voice and appear agitated for an unknown reason. Resident #6 did not make sense when he attempted to explain to staff. Staff attempts at redirection worked at times but not every time. Drinks and snacks were offered but no interventions worked.A progress note, dated 3/10/26 at 9:24 p.m., revealed at approximately 4:00 p.m. that evening Resident #6 started screaming and cursing at everyone without provocation. Resident #6 was redirected and snacks were given, one-to-one supervision initiated, offered to go for a walk with staff, and offered to lay down in his room but Resident #6's behavior continued. The unit manager and social services staff were present attempting to help with Resident #6, and Resident #6 was calmed and sat by the nurses' station.A change in condition note, dated 3/11/26 at 7:28 a.m., revealed Resident #6 had a change in condition and became increasingly agitated, started becoming aggressive toward other residents and staff and eventually began striking out at staff. Emergency services were called, and the police arrived and attempted to subdue Resident #6 but the resident was resistant to them and continued trying to strike out. Paramedics arrived eventually and took Resident #6 to the hospital for an M1 hold (an involuntary, 72-hour emergency mental health detention for individuals appearing to be an imminent danger to themselves or others).A progress note, dated 3/11/26 at 10:41 a.m., revealed no residents on the secured unit were negatively impacted by Resident #6's behaviors and all residents were kept safe during the resident's verbal outbursts and subsequent interactions with police and paramedics. Resident #6 was transported via ambulance to the hospital where he could be evaluated.A progress note, dated 3/12/26 at 9:12 p.m., revealed Resident #6 was in a good mood at the beginning of the evening shift, went to activities and ate his entire dinner. Later that night, Resident #6 became resistive and was yelling. Resident #6 was redirected, given space to calm down and an as-needed (PRN) dose of quetiapine (an antipsychotic medication) was administered with positive results. Resident #6 became calmer and cooperative with care.A progress note, dated 3/13/26 at 7:42 p.m., revealed Resident #6 had been agitated, yelling and using vulgarities at other residents and staff members. A PRN dose of quetiapine was administered to Resident #6. All staff members and residents remained safe, and Resident #6 tolerated the medication well.A progress note, dated 3/13/26 at 8:33 p.m., revealed Resident #6 was being monitored following his visit to the hospital on 3/11/26. Resident #6 had been well-mannered during the nurse's shift and calm for the majority of the shift. Resident #6 did have a few episodes in which he yelled vulgarities at other residents and staff, and was talking about conspiracy theories regarding people molesting their children and babies. A PRN dose of quetiapine was administered with positive results, and the resident was redirected with food and one-to-one supervision. All surrounding residents were unaffected by Resident #6's episodes and all staff and residents remained safe.A progress note, dated 3/14/26 at 6:30 a.m., revealed a PRN dose of quetiapine was administered as Resident #6 was agitated, verbally abusive towards staff and redirection attempts were unsuccessful.A progress note, dated 3/14/26 at 11:14 a.m., revealed Resident #6 had increased behaviors and agitation since approximately 6:30 a.m. that morning. Resident #6 was being verbally abusive to staff, calling them expletives, and had been escalating in his behaviors. Resident #6 became a physical danger to staff, attempting to hit and punch the nurse. Other residents were removed from the area to maintain safety and kept at a distance. Staff members attempted multiple de-escalation techniques including redirection, offering snacks and attempting to have Resident #6 watch television to calm down. Redirection attempts were unsuccessful and Resident #6 continued to damage facility property by striking items and breaking them. Emergency services were called, and the police arrived at 9:00 a.m. that morning, at which point Resident #6 was able to be redirected, cleaned and changed. Resident #6's physician was notified and new orders were received for a one-time dose of lorazepam (an antianxiety medication). Resident #6 continued to be (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitored closely and redirected as needed. Resident #6's room assignment was changed.A progress note, dated 3/15/26 at 3:38 a.m., revealed Resident #6 was agitated and yelling, accusing people of making his pants wet. The one-time dose of lorazepam was administered.A progress note, dated 3/16/26 at 5:55 a.m., revealed Resident #6 was very agitated and was using foul language towards staff and other residents. After 3:00 a.m. that morning, Resident #6 became really upset, said he wanted to leave and began hitting the doors and one of the computers at the nurse's station. The police and Resident #6's physician were notified, and new orders for a one-time dose of quetiapine were received. A psychiatric follow-up note, dated 3/16/26 11:45 a.m., revealed Resident #6 was seen by the psychiatric nurse practitioner to address his episodes of agitation throughout the week prior. Resident #6 had experienced significant behavioral escalation over the past week, with multiple episodes of agitation and physical aggression requiring police intervention and emergency department evaluation. Notable incidents include aggressive behavior on 3/11/26 requiring emergency services transport, increased agitation on 3/14/26 with verbal and physical aggression toward staff, and continued episodes on 3/15/26 and 3/16/26 involving property damage and striking nursing station equipment. Current psychiatric symptoms included severe agitation, verbal aggression with profanity, physical aggression toward staff, paranoid ideation regarding conspiracies about child molestation, and confusion about his clothing being wet. Episodes typically occurred in early morning hours around 3:00 a.m. and appeared unprovoked. Resident #6 demonstrated partial response to current antipsychotic therapy but continued to experience breakthrough agitation requiring medication adjustments and environmental interventions such as room changes and one-on-one staff redirection. Resident #6's quetiapine dose was increased and PRN doses of lorazepam were ordered.A progress note, dated 3/16/26 at 1:43 p.m., revealed Resident #6 had been very aggressive the night prior and had punched and knocked over a computer at the nurses' station. Resident #6 was not able to be redirected at that time and became threatening to the nurse on duty. Resident #6 was eventually able to be calmed down by giving him hot chocolate. The psychiatric nurse practitioner visited Resident #6 and made changes to his medication regimen, which were approved by Resident #6's representative. The resident's representative was informed hot chocolate was able to calm Resident #6 down, and the representative told the staff Resident #6 loved chocolate. A progress note, dated 3/22/26 at 10:37 a.m., revealed Resident #6 had been administered a PRN lorazepam dose. Resident #6 had been verbally agitated that morning and was not able to be successfully redirected.A progress note, dated 3/25/26 at 9:21 p.m., revealed Resident #6 became agitated due to another resident's repeated yelling out. Resident #6 swung at the nurse and yelled at them shut the [expletive] up already and go to bed, no one is stopping you. Multiple staff members then redirected Resident #6 and offered several snacks to de-escalate Resident #6's behavior. Resident #6 was cursing and upset with staff. Other residents present in the area were not disturbed by Resident #6's behavior and were safe.A behavior note, dated 3/27/26 at 4:30 p.m., revealed Resident #6 was presenting with escalating behaviors. Resident #6 was observed talking loudly and expressing frustration about rich people knowing they had money and being okay with poor people not having what they needed, including families and children to care for. A social services staff member accompanied Resident #6 as he walked up and down the hallway, and Resident #6 became further escalated when the social services staff member offered him a soda, which the resident said the offer felt like hush money for the poor. The social services staff member continued walking with Resident #6 for approximately 25 minutes, throughout which the resident appeared to become calmer. Resident #6 eventually accepted a cookie and soda.A progress note, dated 3/27/26 at 8:37 p.m., revealed Resident #6 had been very agitated that afternoon, and was offered beverages and snacks with no success. An administrator came to calm down Resident #6 and offered him a snack, and a PRN dose of lorazepam was administered. Resident #6 calmed down after three hours and went to bed.A progress note, dated 3/28/26 at 2:23 p.m., revealed Resident #6 was still agitated early that morning. Staff attempted to redirect Resident #6 using beverages and snacks but were unsuccessful, so a PRN dose of lorazepam was administered. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6 was still agitated but was slowly calming down.A progress note, dated 3/29/26 at 8:22 p.m. revealed a PRN dose of lorazepam was administered to Resident #6 because he started having behaviors and was raising his hand to staff.A progress note, dated 3/30/26 at 1:04 p.m., revealed Resident #6 continued to have escalated behaviors and was verbally abusive to other residents and staff members. Resident #6 was clenching his fist and waving aggressively to staff and peers. Resident #6 was placed on 15-minute checks.A change in condition note, dated 3/30/26 at 4:59 p.m., revealed Resident #6 was walking past Resident #17 when she started to talk in a loud tone towards Resident #6. An interaction was initiated between the two residents and Resident #6 stepped closer to Resident #17 when Resident #17 swung her outstretched arm to strike him. Resident #6 held onto Resident #17's shoulder/neck area to attempt to stop her from hitting him. Resident #6's physician was contacted and medication adjustments were made, including continuing the as-needed lorazepam order for another 14 days and adjusting his quetiapine dose.C. Resident #171. Resident statusResident #17, age [AGE], was admitted on [DATE]. According to the May 2026 CPO, diagnoses included senile degeneration of the brain, dementia with agitation, depression and mild neurocognitive disorder with behavioral disturbance.The 3/3/26 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. The resident required partial to moderate assistance from staff for most ADLs.The MDS assessment documented the resident did not have physical behaviors directed at others or other behavioral symptoms not directed toward others. The assessment documented the resident had verbal behavioral symptoms directed towards others which occurred on one to three days in the seven-day assessment period.2. Record reviewA change in condition note, dated 3/30/26 at 4:34 p.m., revealed Resident #17 was involved in a resident-to-resident altercation. Resident #17 was sitting in her wheelchair by her door and was yelling about getting her bed made. Resident #6 was walking past Resident #17 and she started to scream at him to just hit her already. Resident #6 then stepped up to Resident #17 and she swung at his stomach to hit him. Resident #6 held onto Resident #17's shoulder/neck area to attempt to stop her from hitting him. A skin check was complete and no redness to her skin was noted. The facility administration, residents' physicians and representatives were notified.III. Incident of physical abuse by Resident #7 towards Resident #6 on 4/16/26A. Facility investigationThe facility investigation, dated 4/16/26, was provided by the NHA on 5/11/26 at 9:00 a.m. The investigation revealed the following:On 4/16/26 at 10:45 a.m. a nursing staff member heard a feminine voice yelling, followed by a male voice talking loudly and more yelling. The nursing staff member began walking down the hallway to search for where the yelling was coming from and observed Resident #6 standing in the doorway of Resident #7's room. The residents were separated and assessed, and Resident #7 was not found to have any injuries. Resident #6 seemed unphased, had a scratch on his left cheek and some redness to the left side of his neck. The residents were separated, placed on 15-minute checks and monitored for 72 hours for any psychosocial changes.An interview with RN #1, dated 4/16/26, revealed he heard Resident #7 yelling get out. Upon entering Resident #7's room, Resident #6 was observed walking towards the doorway, and Resident #7 appeared frantic. Resident #7 said Resident #6 had entered her room and pushed her, so she pushed him back. Resident #6 was unable to recall the incident. An interview with RN #2, dated 4/16/26, revealed the staff member heard yelling from a feminine voice. While trying to identify the source of the yelling, the nursing staff member found Resident #6 in Resident #7's room, and Resident #7 appeared scared. Resident #7 said she was scared, and Resident #6 scared her and pushed her. The residents were separated and redirected to calm them down.The investigation documented Resident #6 had a history of verbal outbursts and anxiety related to delusions he had from his time in military service.The investigation documented Resident #7 had poor impulse control and was territorial of her possessions and her room, and could become verbally aggressive when other residents touched her things or entered her room.The investigation determined the allegation of abuse was substantiated, as redness and discoloration was noted on Resident #6 immediately following the incident. The residents' care plans were updated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following the event, and a stop sign was ordered for Resident #7's door to deter residents from wandering into her room.A. Resident #71. Resident statusResident #7, age [AGE], was admitted on [DATE]. According to the May 2026 CPO, diagnoses included dementia with agitation and mood disturbance, depressive episodes, anxiety disorder, cognitive communication deficits and bipolar disorder.The 4/15/26 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of six out of 15. The resident was independent for most ADLs.The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others.2. Record reviewThe psychosocial care plan, revised 12/14/25, revealed Resident #7 was at risk for decreased psychosocial well-being due to a history of physical and sexual assault. Potential triggers included having people in close proximity or people approaching her quickly without warning. Pertinent interventions included administering medications as ordered and assisting Resident #7 with normalizing her feelings.A change in condition note, dated 4/16/26 at 3:37 p.m., revealed the nurse on duty heard a feminine voice yelling, followed by a male voice talking loudly and more yelling. The nurse searched for the source of the yelling and observed Resident #6 standing in the doorway of Resident #7's room with the door wide open. Both residents were separated and assessed, and Resident #7 did not have any injuries. Resident #6 calmly exited the room and was escorted away by another nurse. Resident #7 was placed on 15-minute checks.IV. Incident of physical abuse by Resident #6 towards Resident #5 on 4/21/26A. Facility investigationThe facility investigation, dated 4/21/26, was provided by the NHA on 5/11/26 at 9:00 a.m. The investigation revealed the following: On 4/21/26 at 9:30 a.m. Resident #5 was sitting in her wheelchair in the hallway by the nurses' station. As Resident #6 walked behind Resident #6, Resident #6 extended his arm in a closed fist and struck the left side of Resident #5's face. Resident #5 was noted to be tearful and non-redirectable for about 15 minutes afterwards. The residents were separated, placed on 15-minute checks and monitored for 72 hours for any psychosocial changes. Resident #6 was given hot chocolate to calm him down.Resident #5 was interviewed on 4/21/26 at 9:50 a.m. Resident #5 said someone hit her in the head. Resident #5 said she was not doing anything wrong and was just sitting there.Resident #6 was interviewed on 4/21/26 at 9:55 a.m. Resident #6 said she (Resident #5) hit him and slammed him in the mouth. Resident #6 said he was trying to push Resident #5 off, and said she hit him in the left side of his mouth. Licensed practical nurse (LPN) #4 was interviewed on 4/21/26 and said she had been standing at the nursing cart talking with Resident #5 when Resident #6 walked behind Resident #5 and quickly hit her on the left side of the face before he walked away.Certified nurse aide (CNA) #5 was interviewed on 4/21/26 and said she was standing at the nurse's station and observed Resident #6 punch Resident #5 on the left side of her head as Resident #5 was praying.The activities assistant was interviewed on 4/21/26, and said she had seen Resident #5 in her wheelchair crying and upset at the nurses' station following the incident.The investigation documented Resident #6 had a history of becoming verbally aggressive and had delusions which could upset him, causing him to become anxious and paranoid.The investigation documented Resident #5 had a history of making noises at times which could be disruptive to other residents, and cognitive impairments which made her unable to notice when her singing or noises were bothering others.The investigation determined the allegation of physical abuse was substantiated as immediately following the incident, Resident #5 had noted redness. The residents' care plans were updated following the event, and one-to-one supervision was implemented for Resident #6 to help prevent reoccurrence.A. Resident #5 (victim)1. Resident statusResident #5, age [AGE], was admitted on [DATE]. According to the May 2026 CPO, diagnoses included Alzheimer's disease, dementia without behavioral disturbance, cognitive communication deficits and unspecified intellectual disabilities.The 3/16/26 MDS assessment revealed the resident had moderate cognitive impairments with aBIMS score of nine out of 15. The resident was dependent on staff assistance for most ADLs.The MDS assessment documented the resident did not have physical or verbal behaviors directedat others or other behavioral symptoms not directed toward others.2. Record reviewA change (continued on next page)

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Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in condition note, dated 4/21/26 at 3:14 p.m., revealed Resident #5 had been in a resident-to-resident altercation. Resident #5 was sitting in the hallway and as the assailant (Resident #6) went behind Resident #5, he made contact with her left facial area. Resident #5 was noted to be tearful and n

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for two (#4 and #16) of seven sample residents reviewed for change of condition assessments out of 14 sample residents. Resident #4 was admitted on [DATE] with diagnoses of dementia, severe, with other behavioral disturbance, pancytopenia (lower than normal count of all three types of blood cells), and protein-calorie malnutrition.On 12/10/25 the facility documented that Resident #4 had decreased oral and fluid intake. On 12/11/25 Resident #4 sustained an unwitnessed fall, where his mattress was found partially off the bed frame. The staff documented a decline in the resident's function and he continued to have decreased oral and fluid intake, had increased weakness and confusion, had unsteady balance and was pale. Despite the nursing staff noticing a change in condition, the facility failed to notify the physician of the change in condition to provide further treatment to the resident. On 12/11/25 at 6:50 p.m. the resident sustained an additional unwitnessed fall. Upon assessment, the resident was noted to have pain. The resident was sent to the hospital for further assessment. While at the hospital the resident was diagnosed with a fractured hip and four subdural hematomas (bleeding between the brain and skull). Following treatment at the hospital he returned to the facility under hospice care on 12/19/25 and passed away on 12/20/25.Specifically, the facility failed to:-Monitor Resident #4 after he experienced a change of condition with multiple falls; and, -Appropriately assess and monitor Resident #16 after sustaining an unwitnessed fall. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy On 12/10/25, Resident #4 began to have decreased oral and fluid intake. On 12/11/25 at 5:00 a.m. Resident #4 had an unwitnessed fall in his room. The physician and his responsible party were notified. The resident was educated to call for assistance before transferring. At 1:06 p.m. the nurse documented he had refused breakfast and had slept most of the morning. The facility failed to adequately monitor the resident after this fall. The neurological checks (measuring level of consciousness, orientation, pupil response, strength, and vital signs) were documented as refused from 7:00 a.m. through 10:00 a.m. At 3:06 p.m. the nurse documented a drop in his blood pressure and an increase in his heart rate as well as a decrease in appetite and fluid intake and generalized weakness resulting in the need for extra assistance with activities of daily living (ADLs). He had been independent prior to fall. The provider was notified and informed the nurse that the nurse practitioner would see the resident the next day. At 6:30 p.m. the nurse documented Resident #4 did not want to eat, was sleeping more, and was unsteady when he tried to stand. At 6:50 p.m. he sustained a second unwitnessed fall from bed. He was unable to state what he was doing, was confused, and had external rotation of his right leg. He was transferred to the hospital. Following surgery and multiple blood transfusions at the hospital he returned to the facility on hospice care. He was only responsive to pain and passed away on 12/20/25. B. Facility notice of immediate jeopardy On 5/7/26 at 3:45 p.m. the nursing home administrator (NHA) and regional director of clinical services were notified that the facility's failure to identify and respond to Resident #4's change of condition created an immediate jeopardy situation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	C. Facility plan to remove immediate jeopardy On 5/7/26 at 6:45 p.m. the facility submitted a final plan for removal of the immediate jeopardy. The plan read: On 5/7/26, Resident #16 was immediately reassessed by the director of nursing (DON) regarding the completion of a neurological assessment after a fall. A complete neurological assessment, including pupillary response to light, level of consciousness, grip strength, extremity movement, and vital signs, was completed and documented. The physician was notified immediately. The physician orders were obtained for a skin tear neurological monitoring was initiated and the care plan was updated. On 5/7/26, the involved licensed nurse received immediate one-on-one education regarding post-fall neurological assessments and documentation requirements. Beginning 5/7/26, the DON/designee completed a review of all residents with falls and concerns about changes in condition to identify any additional residents at risk for post-fall assessment, physician notification, neurological monitoring, or changes in condition that have occurred in the last seven days. The Change of Condition policy and Neurological policy were reviewed on 5/7/26 by the NHA, the DON, and medical director. Beginning on 5/7/26, the staff development coordinator/designee educated all licensed nurses currently in the facility on post-fall assessment and neurological monitoring protocols, including required vital signs, neurological assessment parameters, physician notification requirements, documentation if a resident refuses neurologic monitoring, identifying a change in condition, and documentation expectations. The plan documented any nurse who had not yet received this education would not work the floor until training was completed. Beginning on 5/7/26, the staff development coordinator/designee would educate agency-licensed nurses on the facility's policy regarding the following: The education was uploaded to the agency portal on 5/7/226. The agency platform required agency nurses to complete training before confirming the shift. Beginning on 5/8/26, and continuing daily for 30 days, then weekly for 60 days, then monthly thereafter, the DON would audit all changes of condition occurring in the facility to ensure: A complete neurological assessment was performed immediately following the fall and properly documented, including the use of a penlight for pupil assessment, grip strength, and extremity movement. Complete vital signs were obtained immediately following the fall and at required intervals per protocol. The physician was notified per protocol with documentation of time, information provided, and orders received. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	When residents refused any portion of the assessment, documentation included specifically what was assessed, what was refused, alternative methods attempted, the resident's level of consciousness, and the plan for reassessment. All changes in condition resulted in appropriate interventions and escalation per protocol. Care plans were updated as needed in response to falls and identified risk factors. Audit results will be compiled in a written report that notes the compliance rate, any identified deficiencies, and the corrective actions implemented. Any incidents of non-compliance will result in immediate individual staff education and re-auditing. Beginning on 5/8/26and continuing five times per week for 30 days, then weekly for 60 days, then monthly thereafter the DON/designee will audit 100% of all changes of condition. D. Removal of the immediate jeopardy: Based on the facility's plan above, the immediate jeopardy was removed on 5/7/26 at 7:00 p.m. However, deficient practice remained at a G level, actual harm, isolated. II. Facility policy and procedure The Change in a Resident's Condition or Status policy, revised February 2021, was provided by regional director of clinical services #1 on 5/11/26 at 5:04 p.m. It read in pertinent part, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a(an): accident or incident involving the resident; significant change in the resident's physical, emotional, mental condition; need to transfer the resident to a hospital; and specific instruction to notify the physician of changes in the resident's condition. A significant change of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff; impacts more than one area of the resident's health status; and ultimately is based on the judgment of the clinical staff. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: the resident is involved in any accident or incident that results in an injury including injuries of an unknown source; there is a significant change in the resident's physical, mental, or psychosocial status; or it is necessary to transfer the resident to a hospital. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. The nurse will record in the resident's medical record information relative to changes in the resident's medical and mental condition or status. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Falls-Clinical Protocol policy, revised September 2012, was provided by regional director of clinical services #1 on 5/11/26 at 5:04 p.m. It read in pertinent part, The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. III. Resident #4 A. Resident status Resident #4, age [AGE], was admitted on [DATE], readmitted on [DATE], and passed away on 12/20/25. According to the December 2025 computerized physician orders (CPO), diagnoses included traumatic subdural hemorrhage without loss of consciousness, fracture of right femur (thigh bone), dementia, severe, with other behavioral disturbance, pancytopenia (lower than normal count of all three types of blood cells), and protein-calorie malnutrition. According to the 10/15/25 minimum data set (MDS) assessment Resident #4 had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. He was independent with ADL's and required occasional reminders to complete oral hygiene. He had no previous falls. B. Record review The fall care plan, initiated 12/11/25, indicated Resident #4 was at risk for falls related to cognitive losses and wandering. Interventions included monitoring for changes in condition that increase risk of falls. The potential for fluid deficit care plan, initiated 10/10/25, indicated Resident #4 had the potential for fluid deficit related to dementia. Interventions included monitoring, documenting, and reporting any signs or symptoms of dehydration, such as new onset confusion, dizziness on sitting or standing, increased pulse, headache, fatigue, weakness, or dizziness. The nutritional risk care plan, initiated 10/15/25, indicated Resident #4 had the potential for altered nutrition and or hydration status related to the mini nutritional assessment completed on 10/15/25 with a score of six which indicated malnourished status in the setting of dementia. Interventions included observing for signs or symptoms of malnutrition as evidenced by refusing meals, exhibiting signs or symptoms of dehydration, and reporting to the physician as needed. Review of Resident #4's electronic medical record (EMR) revealed prior to the falls on 12/11/25 Resident #4 was able to make his needs known, he was pleasant and cooperative, had a good appetite, and ambulated independently around the facility. The nursing progress note, dated12/10/25 at 8:40 p.m., revealed Resident #4 refused dinner that evening. The staff offered some snacks and a Magic cup (frozen nutritional supplement), but he (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	refused. The nursing progress note, dated 12/11/25 at 7:01 a.m., revealed the resident was noted on the floor next to his bed. The top of his mattress was half on the floor and half on his bed, the resident unable to tell what happened. He was assessed, cleaned, and was helped back into bed by staff. The note documented the resident's vital signs were stable, neurological checks were started by facility protocols. The resident was instructed to call before any transfer. The note documented the physician and the family were notified. The resident's blood pressure was 102/56 millimeters of mercury (mmHg), pulse 81 beats per minute (BPM). The note documented no changes were observed in his mental status. -However, according to the neurological sheet documentation the fall occurred at 5:00 a.m. The nursing progress note, dated 12/11/25 at 1:07 p.m., revealed Resident #4 was on charting for an unwitnessed fall. The resident's vital signs were stable. He refused to eat this morning and slept most of the morning shift. -However, review of Resident #4's EMR and the neurological sheet documentation revealed no vital sign readings had been documented since 6:30 a.m. (See licensed practical nurse [LPN] #2's interview below). The nursing note, dated 12/11/25 at 3:06 p.m., documented the resident had a change in food and or fluid intake. The resident's BP was 81/57 mmHg (decreased from the documented BP at 7:01 a.m.) and his pulse was 91 BPM (increase from the documented heart rate at 7:02 a.m.). Resident #4 needed more assistance with ADLs, and had general weaknesses. The nurse received a report that the resident had a decrease in appetite and fluid intake over the last three days, which culminated in weakness and a fall this a.m. The resident appeared pale in color. The physician was made aware of the resident's condition and indicated he would have his nurse practitioner see the resident tomorrow. -Review of Resident #4's EMR did not reveal documentation indicating the facility had notified the resident's physician of the resident's decrease in appetite, despite the facility documenting it for three days. The nursing progress note, dated 12/11/25 at 6:30 p.m., revealed Resident #4 continued on monitoring for a decline in condition. The resident's vital signs were: BP 102/63 mmHG, temperature 97.4 degrees Fahrenheit, pulse 90 BPM, respirations 14 breaths per minute, oxygen saturation 95% on room air. The nursing staff attempted to encourage the resident to eat and drink several times, getting him to take sips and eat a Magic cup. Staff attempted to have him eat dinner at bedside sitting up. The resident was confused attempting to stand and was unable to state why and also was unsteady with balance and was redirected back to bed. The resident was checked frequently afterwards and was sleeping. -However, the facility failed to notify the physician of the resident's further decline in his condition. The nursing note, dated 12/11/25 at 6:50 p.m., documented the staff heard a thud coming from the resident's room. Upon entering, the resident was lying on his back on the floor away from the bed. There was external rotation of the right lower extremity. The nurse called for a registered nurse (RN) to assess the resident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The RN assessment, dated 12/11/25, documented the resident was lying on the floor on his back next to the bed. He complained of right hip pain. His right foot was externally rotated. The resident was confused and was unable to state what he was doing. Emergency medical services (EMS) were called and he was transferred to the hospital. -Review of Resident #4's EMR did not reveal documentation indicating the facility assessed the resident's vital signs after this fall. The fall risk observation assessment completed on 12/11/26 at 9:11 p.m. after the second fall, indicated Resident #4's ambulation baseline was independent prior to his decline in conditions in which the resident became weaker and was in need of assistance with transfers and ambulation. The 12/11/26 hospital emergency room documentation revealed the resident's vital signs were BP 79/45 mmHg and his pulse was 94 BPM. The note documented he had experienced generalized weakness for about one week, with poor dietary intake and output. He had right hip pain and external rotation of the right foot. The resident was pale throughout. The right lower extremity was slightly shortened. There was tenderness over the right greater trochanter (bony protrusion). The resident was also reported to be hypotensive (low BP) en route to the emergency room. One liter of intravenous (IV) fluid was ordered. The resident presented with one or more acute injuries that posed a threat to life and/or bodily function. The resident had a hemoglobin (iron-rich protein in red blood cells) of 4.5 grams per deciliter (g/dL) (normal range 13.5 to 17.5 g/dL). There were concerns that the resident's shock may be multifactorial in the setting of hemorrhage. He had a mildly displaced right sided intertrochanteric hip fracture. There was an acute appearing subdural hematoma along the cerebral convexities (bleeding on the top and sides of the brain) bilaterally measuring 1.1 centimeter (cm) on the right and 1 cm on the left. There was a right parafalcine (between the inner layers of the brain) subdural hematoma measuring 7 millimeters (mm) in thickness. There was also a subdural hematoma in the right tentorium (area separating the cerebrum from the cerebellum) measuring 3 to 4 cm in thickness. He was admitted to the trauma intensive care unit with diagnoses of right intertrochanteric femur fracture, acute blood loss anemia (traumatic), and hemorrhagic shock, BP 79/55 mmHg. The nursing progress note, dated12/19/25 at 3:49 p.m., revealed Resident #4 returned to the facility on hospice care. The nursing progress note, dated 12/20/25 at 6:40 a.m., revealed the resident passed away. C. Staff interviews RN #2 was interviewed on 5/7/26 at 11:00 a.m. RN #2 said when a fall occurred the resident was to be assessed by an RN prior to moving them. RN #2 said vital signs and neurological checks were started if the fall was unwitnessed or they were observed to strike their head. She said if there was a decline in a resident's condition the provider was to be notified and if the nurse felt the resident needed labs drawn, x-rays, or needed to be sent to the hospital and the physician was reluctant to order those things, the nurse could make a nursing judgement call and notify the medical director to obtain orders. LPN #3 was interviewed on 5/7/26 at 11:15 a.m. LPN #3 said if a resident had a significant change in condition she would assess them and call the provider for orders and let the unit manager and the DON know. She said a change of condition assessment was to be completed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Certified nurse aid (CNA) #1 was interviewed on 5/7/26 at 11:30 a.m. CNA #1 said if a resident refused to eat or drink she would offer different choices and if they refused three times, she said she could not force them to eat or drink. She said if it became a repeated refusal she would then notify the nurse. CNA #2 was interviewed on 5/7/26 at 1:00 p.m. CNA #2 said if she noticed any change in a resident's condition that was out of their normal behavior she would notify the nurse and if the nurse did not act on her concerns she would go to management and the DON. The DON was interviewed on 5/7/26 at 11:45 a.m. The DON said when a fall occurred or there was a change in a resident's condition, nursing staff were to complete a change of condition assessment, notify the provider, and the responsible party. She said neurological checks were to be started after a fall and completed in their entirety if the resident was observed to hit their head or if the fall was unwitnessed. She said if a resident refused all or part of the assessments, the nurse was supposed to obtain and document as much of the required information on the form as possible. She said she was not notified of Resident #4's decline in condition and vital signs. She said if she had been notified she would have had the resident sent to the hospital prior to the second fall. She said if nurses had doubts about what they were to do they should reach out to her and the issue could be escalated to the provider or the medical director for orders if necessary. LPN #2 was interviewed on 5/11/26 at 10:20 a.m. She said when she documented the progress note on 12/11/25 at 1:07 p.m. related to Resident #4 sleeping all morning and refusing to eat, that behavior was unusual for him. She said if a nurse noticed that something was off from the resident's normal behavior the provider should be notified for orders if indicated. She said she did not notify Resident #4's provider of the changes she noticed in his condition. She said frequent checks on Resident #4 were not timed but she would lay eyes on him if she passed his room. She said she passed on to the nurse that relieved her that day that Resident #4 was not doing well and to keep an eye on him. She said she documented that Resident #4 refused the neurological checks at 7:00 a.m., 7:30 a.m., 8:00 a.m., 9:00 a.m., and 10:00 a.m. on 12/11/25 because he pushed her away each time she tried to obtain his blood pressure. She said he stayed in bed that entire morning. She said she did not attempt any other areas of the neurological check assessment. She said if a resident refused the assessment she would normally document a progress note of the refusals and the resident's condition, but she did not do that. IV. Resident #16 A. Resident status Resident #16, age [AGE], was admitted on [DATE]. According to the May 2026 CPO, diagnoses included dementia with behavioral disturbance, generalized muscle weakness, unsteadiness on feet, difficulty in walking and repeated falls. The 3/13/26 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of zero out of 15. The resident required substantial assistance from staff for most ADLs. B. Observations and record review During a continuous observation on 5/7/26, from 11:54 a.m. to 12:38 p.m., the following was observed: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	At 11:54 a.m. Resident #16 was sitting up on the floor in the common area with her legs tucked to the side and supporting her weight on her arm. Multiple nursing staff members were attending to the resident, including regional director of clinical services #2 and the DON. Resident #16 had an open area on her forehead approximately two centimeters (CM) by two CM which was bleeding, blood on her hand and a small puddle of blood on the floor. At 11:56 a.m. regional director of clinical services #2 began performing a neurologic assessment on Resident #16 using a cellphone flashlight. Regional director of clinical services #2 held the cellphone flashlight toward Resident #16's face as she turned her head away from the light. Regional director of clinical services #2 and the DON helped Resident #16 straighten her legs out in front of her and performed a brief range of motion assessment on the resident's legs. At 12:01 p.m. regional director of clinical services #2 and the DON assisted Resident #16 to a standing position using a gait belt around the resident's waist and walked with her to her room, where she was assisted into a chair near her bed. Regional director of clinical services #2 and the DON obtained Resident #16's vital signs using a vitals machine and performed another neurological assessment using a cellphone flashlight. Resident #16 turned her head away repeatedly and was squinting her eyes shut while the light from the flashlight was used to attempt to assess her pupil reaction for the neurological assessment. LPN #1 removed the vital signs machine from the room and brought in wound cleanser and gauze, and the DON and regional director of clinical services #2 began cleaning the wound to Resident #16's forehead. At 12:08 p.m. regional director of clinical services #2 and the DON closed Resident #16's door to perform a skin check and assist the resident with getting dressed in clean clothes. At 12:17 p.m. the DON and regional director of clinical services #2 assisted Resident #16 back into the dining room where the resident sat in a dining room chair. At 12:24 p.m. RN #3 reviewed with LPN #1 how to use the facility's neurological assessment sheet and told LPN #1 when Resident #16 would be due to assess her next set of vitals measurements. At 12:30 p.m. LPN #1 approached Resident #16 in the dining room and began collecting vital signs measurements using the vitals machine. LPN #1 used the vitals equipment to assess Resident #16's blood pressure, heart rate and blood oxygen saturation. LPN #1 then recorded this information on the neurological assessment sheet. -However, LPN #1 did not have any flashlight or pen light available to assess Resident #16's pupillary response. At 12:38 p.m. the neurological assessment sheet for Resident #16 was observed on LPN #1's medication cart. The sheet contained vital signs measurements for Resident #16 which were documented to have been taken at 12:15 p.m. and 12:30 p.m. on 5/7/26. Resident #16's pupils were documented as having been equal, round and reactive to light at the time of both the 12:15 p.m. and 12:30 p.m. assessments. -However, LPN #1 was not able to assess Resident #16's pupillary response to light during the 12:30 p.m. assessment period (see above). -Additionally, the vital signs machine had been removed from Resident #16's room prior to her door (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	05/11/2026

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	being closed at 12:08 p.m. C. Staff interviews LPN #1 was interviewed on 5/7/26 at 12:38 p.m. LPN #1 said she was not sure how Resident #16 had fallen as she was assisting another resident at the time. She said she only knew the resident had fallen when she heard a thump sound behind her. LPN #1 said the unit managers and the DON had immediately begun assessing Resident #16, and said she would continue performing neurological assessments for the resident per facility policy. LPN #1 said when performing neurological assessments, she only needed to look at the resident's pupils and see if they were reactive. LPN #1 said she did not have to use a light source when assessing the resident's pupils, and said the unit manager and the DON had assessed Resident #16's pupils before they assisted her up from the floor. LPN #1 said the unit managers and DON had used a cellphone flashlight to assess Resident #16 because her pen light batteries were dead. The DON and regional director of clinical services #2 were interviewed together on 5/7/26 at 1:33 p.m. The DON said neurological assessments were performed after a resident sustained a fall to monitor the resident for any change in neurological status, vital signs measurements, mentation or mental status. The DON said when performing neurological assessments, the nursing staff were looking to see if the resident was alert and oriented, had equal hand grasps on both sides, their pupils were reactive to light and equal between the left and right eye, if they had any pain, and their vital signs. The DON said pupil reactivity was assessed using a flashlight or a pen light. The DON said LPN #1 should have used a light source to assess Resident #16's pupillary reaction.