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	12/01/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the main kitchen. Specifically, the facility failed to ensure:-Beard nets were worn while preparing food in the main kitchen;-Hand hygiene was conducted during meal service and dishwashing; and,-Food was labeled and dated in the walk-in refrigerator, walk-in freezer and reach-in refrigerators. Findings include:I. Failure to ensure beard nets were worn in the kitchenA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 9/29/25. It revealed in pertinent part, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens and unwrapped single-service and single-use articles. (Chapter 2)B. Facility policy and procedureThe Preventing Foodborne Illness Employee Hygiene and Sanitary Practices policy, revised November 2022, was received from the director of nursing (DON) on 9/25/25 at 8:35 a.m. It read in pertinent part, Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens.C. ObservationsOn 9/22/25 at 9:59 a.m. an unidentified male dietary aide (DA) with a goatee was standing by the three-compartment sink in the kitchen. He was not wearing a beard net. On 9/22/25 at 12:26 p.m. the unidentified male DA with a goatee was in the kitchen without a beard net on. On 9/24/25 at 10:06 a.m. the unidentified male DA with the goatee was in the kitchen without a beard net on washing dishes in the three-compartment sink. On 9/24/25 at 12:14 p.m. an unidentified male DA with a full beard came into the kitchen and did not put on a beard net. He went into the back area of the kitchen and began helping with food preparation after washing his hands. D. Staff interviewsThe dietary supervisor (DS) was interviewed on 9/25/25 at approximately 3:00 p.m. He said beard nets should have been worn. II. Failure to perform hand hygiene appropriately during meal service and dishwashingA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 9/29/25. It revealed in pertinent part, The Colorado Retail Food Regulations, (3/16/24) and retrieved on 5/20/25 read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15)B. Facility policy and procedureThe Preventing Foodborne Illness Employee Hygiene and Sanitary Practices policy, revised November 2022, was received from the DON on 9/25/25 at 8:35 a.m. It read in pertinent (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	part, Employees must wash their hands: after personal body functions (toileting, blowing/wiping nose, coughing, sneezing); after using tobacco, eating or drinking; whenever entering or re-entering the kitchen; before coming in contact with any food surfaces; after handling raw meat, poultry or fish and when switching between working with raw food and working with ready-to-eat food; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks; and/or after engaging in other activities that contaminate the hands.C. ObservationsDuring a continuous observation on 9/24/25, beginning at 11:00 a.m. and ending at 12:41 p.m., the following was observed during the meal service in the main kitchen:At 11:00 a.m. meal service began. [NAME] (CK) #1 was serving the main meal and DA #2 was making and plating the special orders. DA #2 washed her hands and donned a pair of gloves. At 11:07 a.m. DA #2 doffed (took off) her gloves and donned a new pair of gloves. She did not perform hand hygiene after taking her gloves off and before putting on new gloves. At 11:13 a.m. DA #2 took off her gloves after making a grilled cheese sandwich and donned a new pair of gloves without performing hand hygiene. At 11:15 a.m. CK #1 scratched her head underneath her hat, did not perform hand hygiene afterwards and continued to serve the meal. At 11:16 a.m. DA #2 cut the crust off of a peanut butter and jelly sandwich, took her gloves, placed the gloves on the cutting board with the crust from the sandwich. She then picked the used gloves and crust with her bare hands and threw all of it into the trash bin. Without performing hand hygiene, she then donned a new pair of gloves. At 11:20 a.m. without performing hand hygiene after she scratched her head, CK #1 left the serving line and returned with a new bag of paper plates. She opened the bag of plates and took out a large stack of paper plates, closed the opened bag of plates and began to serve the meal without performing hand hygiene. At 11:37 a.m. CK #2 switched spots with CK #1. At 12:20 p.m. DA #1 was washing dishes in the three-compartment sink with gloves on. He grabbed some dirty containers for the room trays so he could wash them for the meal service line. After placing some of the dirty lids and bottoms into the wash compartment, he went to the clean side and removed the clean dishes and put them away. He did not change his gloves or perform hand hygiene or remove his gloves after touching the dirty dishes and prior to touching the clean dishes. At 12:21 p.m. CK #2 touched the backside of her pants and began serving meals without performing hand hygiene. D. Staff interviewsThe DS was interviewed on 9/25/25 at approximately 3:00 p.m. He said hand hygiene should be performed after taking off gloves and when hands were soiled. III. Failure to ensure food was labeled and dated in the walk-in freezer, walk-in refrigerator and reach-in refrigerators. A. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, (3/16/24), retrieved on 9/29/25. It read in pertinent part,A date marking system that meets the criteria may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded or using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the department upon request. (Chapter 3-29)B. ObservationsOn 9/22/25 at 7:10 a.m., during the kitchen tour, the following items were found in the main kitchen walk-in freezer:-An unidentified meat wrapped in tinfoil, that was not labeled or dated;-An unidentified meat that inside of a plastic bag, that was not labeled or dated;-An open bag of breakfast sausages that was not labeled or dated; and,-A large black bin filled with an assortment of different plastic bags filled with different meat patties, frozen mixed vegetables and unidentified foods that were not labeled or dated. On 9/22/25 at 7:16 a.m. the following items were found in the main kitchen walk-in refrigerator:-An opened bag of liquid eggs, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	without an open date; and,-An unidentified meat that was wrapped in plastic wrap that was not labeled or dated.On 9/24/25 at 10:06 a.m. in the walk-in refrigerator, there was a large container of food that resembled peeled and diced potatoes in water, which was not labeled or dated. On 9/24/25 at 11:32 a.m., during lunch service, DA #2 made a tuna salad sandwich; the tuna salad container was not labeled or dated. On 9/24/25 at 11:55 a.m., during lunch service, DA #2 reheated spaghetti with marinara sauce; the marinara sauce container was not labeled or dated. On 9/25/25 at 8:49 a.m. the following items were found in the reach-in refrigerators that was located next to the steam tables and where the facility stored sandwich supplies:-A large container of tuna salad that was not labeled or dated;-A large container of marinara sauce that was not labeled or dated; and,-An unidentified soup that was not labeled or datedC. Staff interviewThe DS was interviewed on 9/25/25 at approximately 3:00 p.m. He said everything should be labeled and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection. Specifically, the facility failed to:-Ensure there were monitoring measures maintained for all control measures identified that may contribute to the spread of legionella (a type of bacteria that can cause legionella disease, a severe form of pneumonia): -Ensure the facility water management plan was reviewed annually; and,-Ensure the facility water management plan was personalized and specific to the facility. Findings include:I. Facility policy and procedureThe Legionella Water Management Program policy and procedure, revised June 2021, was provided by the nursing home administrator (NHA) on 9/25/25 at 12:27 p.m. It read in pertinent part, The purposes of a water management program are to identify areas in the water system where Legionella bacteria can grow and spread.Specific measures used to control the introduction and/or spread of legionella (temperatures and disinfectants)include; a system to monitor control limits and effectiveness of control measures.The water management program is reviewed at least once a year. II. Water Management Plan A. Record reviewThe Water Management Plan, dated 12/20/23, was provided by the NHA on 9/24/25 at approximately 10:00 a.m. and it revealed in pertinent part,Control measures and corrective actions include: Ice coolers are put on a daily cleaning schedule, HVAC (heating, ventilation and air conditioning) filters are serviced twice a year, The juice machine juice gun is soaked daily by dietary staff in a disinfectant, taken apart weekly and cleaned, Hot tubs should be drained, cleaned and refilled every three to four months and plumbing should be cleaned every 12 months; and, Decorative fountains should be run daily to avoid prolonged idle periods. On 9/25/25 at 10:18 a.m. audit logs for the daily cleaning of the ice coolers, the weekly cleaning of the juice machines, quarterly draining/cleaning of the facility hot tubs, and the twice yearly service of the facility HVAC were requested from the NHA via email on 9/25/25 at 10:18 a.m. -These documents were not provided during the surveyB. Staff interviews The maintenance director (MTD) was interviewed on 9/24/25 at 2:51 p.m. He said the facility followed the audit and cleaning schedule of the facility water management program to prevent the spread of legionella bacteria. The MTD said the program was discussed monthly in the facility quality assurance meeting. He said if the facility has moving water in the building and the water was not stagnant, then the water management plan was working. The regional clinical resource was interviewed on 9/24/25 at 3:34 p.m. She said the water management program should be reviewed and updated annually. The regional clinical resource said the facility did not have any decorative fountains and that should have been removed from the program control measures. She said it was important to keep the water plan up to day to prevent the risk of water borne illness and infections to the residents. She said the water management plan was outdated and not specific to the facility's areas of monitoring.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect for two of four units. Specifically, the facility failed to:-Provide Resident #155 privacy while he used the restroom, and,-Staff announced themselves prior to entering residents' rooms. Findings include:I. Resident #155A. Resident statusResident #155, age [AGE], was admitted [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the skull) without loss of consciousness, dementia with agitation, cancer of the thyroid gland, and rheumatoid arthritis. The 6/25/25 minimum data set (MDS) assessment revealed Resident #155 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The MDS further revealed Resident #155 was independent for all of his activities of daily living (ADL). B. ObservationsOn 9/23/25 at 9:14 a.m. certified nurse aide (CNA) #3 knocked on Resident #155's door then immediately walked into his room. Resident #155 was heard yelling, Hey, I'm on the toilet! CNA #3 then said, Sorry, can I grab your tray? CNA #3 then came out of his room without his tray and was heard saying to an unidentified CNA trainee, He's a very private person.II. Failure to knock before entering resident roomsA. ObservationsOn 9/23/25 at 9:14 a.m. after CNA #3 entered Resident #155's room, she proceeded to go from room to room on the 800 hall, knocking and immediately entering the residents' rooms to gather room trays. She did not announce herself upon entering the rooms. On 9/24/25 at approximately 2:22 p.m. an unidentified male CNA was going from room to room down the 700 hall taking residents' dinner orders. He was knocking then immediately entering the rooms (without announcing himself), without waiting for the residents to respond. B. Resident group interviewA group interview was conducted on 9/23/25 at 1:00 p.m. with 10 (#25, #31, #50, #2, #124, #140, #151, #152, #10 and #17) alert and oriented residents per facility and assessment. The residents said the staff knocked on their doors, but did not wait for a response. The residents said the staff knocked, then walked right in. The group called it the knock then walk. III. Staff interviewsCNA #2 was interviewed on 9/25/25 at 3:52 p.m. She said she knocked on the resident's doors before entering their rooms. She said she waited 30 seconds to one minute before entering the resident's room if she did not hear a response from the resident. She said if a resident was using the bathroom when she entered the room, the bathroom door was s usually closed or the resident would tell her before she entered the room. The director of nursing (DON) was interviewed on 9/25/25 at 3:56 p.m. She said the staff should knock before they enter a resident's room. She said staff should be asking if they could enter before they enter the room. She said staff should wait up to fifteen seconds before entering the room if they did not get a resident's response. She said there were certain circumstances, such as falls or other medical emergencies, where she did not want staff waiting too long before entering the resident's room.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure medications and biologicals were stored and labeled properly according to professional standards in three of four medications rooms, one of five medication carts and one of one vaccine storage refrigerators.Specifically, the facility failed to:-Ensure expired vaccines were removed from refrigerators;-Ensure Tubersol (used to test for tuberculosis) vials were dated upon opening;-Ensure vaccinations were not stored in dormitory style refrigerator;-Ensure expired insulin pens were removed from the medication cart;-Ensure expired medications were removed from over the counter medications supply; and,-Ensure discarded medications were destroyed timely. Findings include:I. Professional referenceAccording to the Vaccine Storage and Handling Tool-kit, dated 3/29/24, retrieved on 9/29/25, from https://www.cdc.gov/vaccines/hcp/downloads/storage-handling-toolkit.pdf, Do not store any vaccine in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances. These units have a single exterior door and an evaporator plate/cooling coil, usually located in an icemaker/freezer compartment. These units pose a significant risk of freezing vaccines even when used for temporary storage.According to the Tuberculin Purified Protein Derivative Tubersol package insert, retrieved on 9/29/25 from https://www.fda.gov/media/74866/download, A vial of Tubersol which has been entered and in use for 30 days should be discarded.According to the Lantus glargine insulin package insert, retrieved on 9/29/25 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/021081s076lbl.pdf, When not in use store in refrigerated temperatures of 36 to 46 degrees Fahrenheit (F). When in use, it can be kept at room temperature for up to 28 days.II. Facility policy and procedureThe Medication Labeling and Storage policy, revised February 2023, was received from the nursing home administrator (NHA) on 9/25/25 at 9:30 a.m. it revealed in pertinent part, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and are discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.Multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date.The Discarding and Destroying Medication policy, revised June 2025, was received from the NHA on 9/25/25 at 9:30 a.m. It read in pertinent part, Medications that cannot be returned to the dispensing pharmacy are disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and controlled substances. Except for the following situations, medications are not returned to the pharmacy for credit or disposal, Refusal upon delivery due to order change, Refusal upon delivery due to resident's death or expiration; and/or Pharmacy medication error in dispensing.III. Vaccine failuresA. ObservationsOn 9/24/25 at 1:18 p.m. the vaccine refrigerator on the Garden unit was reviewed with licensed practical nurse (LPN) #1 and the infection preventionist (IP). The vaccine refrigerator contained the following:One vial of Tubersol with an open date of 6/10/25;One vial of Tubersol with open date of 6/30/25;Eight vials of the COVID-19 vaccine mRNa Spikevax 2024-2025 formula that expired 6/2/25; and, Nine vials of influenza Fluad 2024-2025 formula expired on 5/14/25.B. Staff interviewsThe IP was interviewed on 9/24/25 at 1:20 p.m. She said Tubersol was only good for 30 days once opened and it could not be effective if used past the 30 days. The IP said it was the responsibility of the night nurses to review the medication refrigerators including the vaccine refrigerators. The IP said she would dispose of the expired vaccines. IV. Medication room failuresA. Observations On 9/24/25 at 10:47 a.m. the Evergreen medication refrigerator was observed (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with registered nurse (RN) #2. The refrigerator contained one open vial of Tubersol with no open date.-The facility failed to label the vial with an open date.The medication refrigerator also contained three vials of Gentamicin Sulfate (antibiotic) 40 milligrams per milliliter (mg/ml). Two vials expired July 2025 and the third vial expired May 2025-The facility failed to remove expired medications from the medication refrigerators. On 9/24/25 at 11:02 a.m the Garden medication room and refrigerator was observed with licensed practical nurse (LPN) #1. The medication refrigerator had one bottle of expired magnesium citrate (laxative) that expired 9/22/25 and one open Lantus insulin pen with no open date. -The facility failed to remove expired medication from the medication refrigerator. The facility failed to have an open date on an insulin pen. The Garden medication room had a large box overflowing on the floor and a cabinet full of discontinued medications belonging to residents who no longer resided in the facility. -The facility failed to have medications sent back or discarded timely. On 9/24/25 at 11:25 a.m. the Aspen medication room was observed with LPN #2. There were two open vials of Tubersol both had no open date. -The facility failed to label vials with open dates.The Aspen medication refrigerator was a dormitory style refrigerator. The freezer compartment was observed to have excess ice built up around the freezer compartment.-The facility failed to maintain the refrigerator clean and failed to store Tubersol in the appropriate refrigerator (see professional references above).The Aspen medication room had a cabinet labeled diabetic management. The cabinet contained over the counter medications. The following over the counter medications were found in the cabinet:One bottle of Vitamin C 500 mg that expired August 2025; One bottle of Zinc 50 mg that expired March 2025; Two bottles of Fiber laxative that expired July 2025; One box with bisacodyl suppositories 10 mg that expired April 2025; One bottle of Aspirin 325 mg that expired August 2025; One bottle of Oystershell plus Vitamin D 250 mg that expired July 2025; One bottle of Vitamin D 25 micrograms (mcg) that expired July 2025; and,One bottle of Docusate sodium (stool softener) 100 mg that expired June 2025. B. Staff interviews RN #1 was interviewed on 9/24/25 at approximately 10:50 a.m. during the observation of the medication refrigerator on the Evergreen unit. She said it was important to label vials with open dates to know when they expire as they were not as effective if used past the recommended open date. RN #2 said the gentamicin vials were expired and should have been removed from the refrigerator the month they expired. RN #2 said she would take the three vials of expired gentamicin and one vial of Tuberosol to the unit manager or the director of nursing (DON).LPN #1 was interviewed on 9/24/25 at approximately 11:05 a.m. during the observation of the garden medication room. He said open dates were important to ensure medication was used before they expired or they may not be as effective if used past the recommended date. LPN #1 said he did not know how long insulin was good once opened. LPN #1 said he was going to discard the expired medications. LPN #1 said the medication room had a cabinet for discontinued medications but it was full and the staff started to add them to the box on the floor. LPN #1 said the unit manager or DON were to dispose of the discontinued medications but he did not know when this was to occur. LPN #1 said the box had been there a while. LPN #1 said the nurses working the floor, unit manager and the DON had keys to the medication rooms. LPN #2 was interviewed on 9/24/25 at approximately 11:25 a.m. during the medication room observations. LPN #2 said she was not aware how long Tubersol vials were good for once accessed. LPN #2 said she did not feel the ice built up would cause any issues with medications stored in the refrigerator.RN #1 was interviewed on 9/24/25 at 11:34 a.m. when LPN #2 asked him about how many days the Tubersol was good once opened. RN #1 said it was good for 28 days. RN #1 said he did not know who was responsible for cleaning the ice out of the refrigerator. RN #1 said the ice that builds up could cause the refrigerator to not regulate temperatures effectively. RN #1 said it was the responsibility of the nurses to review the medication rooms and carts for expired medications. UM #2 was interviewed on 9/24/25 at 1:25 p.m. He said when the DON call\eds for the discontinued medications the nurses would take them to her for her to return them to the pharmacy or be destroyed appropriately. UM #2 said he believed she called for the medication to be destroyed monthly. V. Medication cart failuresA. ObservationsOn (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/24/25 at 11:20 a.m. the 600 hall on Aspen medication cart was observed with LPN #2. The following was observed:One open insulin glargine pen with an open date of 8/16/25; and, One open Lantus insulin pen with an open date of 8/1/25.-The facility failed to identify and dispose of insulin pens after the recommended 28 days from first access (see professional reference above). B. Staff interviewsLPN #2 was interviewed on 9/24/25 at approximately 11:25 a.m during observations of a medication cart and medication room on the Aspen unit. LPN #2 said the insulin vials were good for one month after the first use. LPN #2 said if the insulin was used after one month it may not be as effective for the resident. LPN #2 said she would discard the insulin pens, check the medication refrigerator for stock if not found she would contact the pharmacy to get them ordered. VI. Additional staff interviewsThe DON was interviewed on 9/24/25 at 1:58 p.m. She said it was the responsibility of all nurses and the unit managers to complete medication room and cart checks for expired medications. The DON said she was informed by her staff of the above observations and findings of expired medications found in the medication carts and rooms.The DON said the over the counter medications should not have been stored in the medication room because the facility kept over the counter medication stored in the central supply room in the basement. The DON said discontinued medications could be sent back to the pharmacy once a month. The DON said discontinued medications stored in the medication rooms could lead to the medication leaving the room or being placed back into the medication cart, which could lead to potential medication errors. The DON said she was not aware of the amount of discontinued medications in the cabinet and the box in the Garden medication room that needed to be sent back to the pharmacy. The DON said open dates were important to ensure the medication were used or discarded by the use of dates recommended by the manufacturer. The DON said insulin was good for 28 days from first access and Tubersol was good for 30 days from initial access. The DON said it was the IPs responsibility to monitor vaccines in the facility. The DON said the facility has always stored medications and vaccines in dormitory style refrigerators with no concerns. The DON said the medication refrigerators were cleaned as needed. The DOnNsaid if ice builds up it could cause storage concerns and would need to be defrosted. The DON said the medications in the refrigerator needing to be defrosted would be temporarily moved to another medication refrigerator while they defrosted the freezer. The DON said once the medication refrigerator was defrosted and temperature maintained within range the medication could safely be returned to the original refrigerator.

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

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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, observations, and interviews, the facility failed to provide supervision, assistance, services, and implement effective person centered interventions to prevent falls with injuries for one (#156) of three residents reviewed for accidents/hazards out of 71 sample residents.Specifically, the facility failed to ensure the staff were aware and implemented Resident #156's fall interventions consistently. Findings include:I. Facility policy and procedureThe Fall Risk policy, revised March 2018, was provided by the nursing home administrator (NHA) on 9/25/25 at 9:21 a.m. It read in pertinent part,The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. In conjunction with the attending physician, staff will identify and implement relevant interventions (hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. II. Resident #156A. Resident statusResident #156, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO) diagnoses included dementia, diabetes and osteoporosis (a disease that weakens the bones, making them less dense and thinner).The 9/12/25 minimum data set (MDS) assessment revealed the resident had significant cognitive impairments with a brief interview of mental status (BIMS) score of one out of 15. The resident required extensive assistance with showers and transfers and used a wheelchair for mobility. The assessment revealed the resident had two falls with injury since the last review period. B. Observations On 9/22/25 at 8:45 a.m. Resident #156 was sleeping in her bed. The door was closed and the call light was on the floor. On 9/23/25 at 12:56 p.m. Resident #156 was asleep in her. The door closed. C. Record reviewThe fall care plan, revised on 6/3/25, revealed the resident was at risk for falls due to a history of falls with fractures and dementia. Interventions included to ensure the resident's call light was within reach (initiated 6/3/25), ensure the resident was wearing appropriate footwear when ambulating or mobilizing in her wheelchair (initiated 6/3/25), leaving the door open while the resident was in her room (initiated 6/30/25), assisting the resident with transfers after meals to the bed to lie down (initiated 8/8/25), ensuring the resident was in high visible areas during waking hours as tolerated (initiated 8/19/25), having the physician review the resident's blood sugars, metformin (diabetic medication) and A1C (diabetic blood test) (initiated 8/21/25). Review of the certified nurse assistant (CNA) abbreviated care plan (tasks) did not reveal resident specific fall interventions. A nursing progress note, dated 6/2/25, revealed the resident had been admitted after an intracapsular fracture (a bone break that occurs within the joint capsule) of left femur. A physician note, dated 6/3/25, revealed the resident had significant cognitive deficits and was a high risk for falls with physical injury. 1. Fall on 6/29/25 - unwitnessed A change of condition note, dated 6/29/25, revealed the resident was found on the floor facing the wall towards the headboard in between her wheelchair and her bed. A puncture wound was noted to the right elbow, bruising to the right knee and bruising with a raised area to the back of her head near the crown. The resident was assessed by the nurse. The physician and the family were notified. An exam revealed a small laceration to her right elbow. The physician r ordered Xrays and wound care treatment. A follow up note, dated 6/30/25, revealed the Xrays showed no abnormalities. A fall interdisciplinary team (IDT) note, dated 6/30/25, revealed risk factors identified included: difficulty locking breaks when self transferring, impulsivity, primarily Russian speaking, poor safety awareness and walking without assistance. Prior interventions were to keep her bed in the low position and ensure call light was within reach. The new interventions implemented were to add brake extenders to the wheelchair and to ensure the resident's room door remained open while the resident was in the room. -However, observations revealed the resident's door was not open while the resident was in her room (see observations above).2. Fall on 8/4/25- unwitnessedA change of condition note, dated 8/7/25, revealed the resident had an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unwitnessed fall in her room while trying to move the tray from the side table into the vanity. The resident stated she felt dizzy and fell to the ground. The nurse assessed the resident and was able to get the resident into a standing position.A physician assistant progress note, dated 8/7/25, revealed the resident was complaining of pain to the left side of her face but her physical exam was unremarkable.A health status note, dated 8/7/25, revealed at the time of the unwitnessed fall, the resident was observed laying on her back on the floor in her room. The resident was assessed by the nurse and a reddened area to her left cheek was observed. The area was tender to the touch and also had a 2 centimeter (cm) scratch. Through the translator line, the resident said she had gotten up out of her bed to do the dishes and her legs had given out, causing her to fall. A fall IDT note, dated 8/8/25, revealed risk factors identified included: difficulty locking breaks when self transferring, impulsivity, primarily Russian speaking, poor safety awareness and walking without assistance. Prior interventions were to keep her call light within reach, transfer height bed, brake extenders and to ensure the door to her room remained open while the resident was in there. The new interventions implemented were to provide supervision from staff after meals for the resident to transfer and lie down. 3. Fall on 8/18/25 - unwitnessedA nursing note, dated 8/18/25, revealed the nurse was called to assess the resident after she was found on her bathroom floor after an unwitnessed fall. The resident had no complaints of pain and was wearing non-skid socks. A fall IDT note, dated 8/18/25, revealed risk factors identified included: primarily Russian speaking, dementia and ambulating without assistance. Prior interventions were to keep her call light within reach, transfer height bed, brake extenders, ensure the door to her room remained open while the resident was in there and to provide supervision from staff after meals for the resident to transfer and lie down. The new interventions implemented were for the resident to remain in high visibility areas during waking hours as tolerated unless assisted to lie down.4. Fall on 8/21/25 - unwitnessedA change of condition note, dated 8/21/25, revealed the resident was heard screaming in her room and was found sitting on the floor by her bed with her shoes on. A fall IDT note, dated 8/21/25, revealed risk factors identified included: history of falls and high risk medications. Prior interventions were to ensure non-skid socks, labs, de-cluttered the resident's bed, provide the resident education to call for assistance with care and adding the resident to the restorative program. The new interventions implemented were to call the medical director to review the resident's blood sugars and A1C.-Prior interventions of labs, de-cluttered the resident's bed, providing the resident education to call for assistance with care, and adding the resident to the restorative program were not included on the resident's care plan. A physician assistant note, dated 8/22/25, revealed the resident had multiple falls since the month of August 2025 without any significant injuries, recent labs had been within acceptable ranges. The note documented the falls were most likely exacerbated by generalized weakness/debility, poor safety awareness, and dementia.III. Staff interviewsLicensed practical nurse (LPN) #2 was interviewed on 9/24/25 at 1:53 p.m. She said she looked at the resident's CPO for fall interventions. LPN #2 said she was unable to locate specific fall interventions for Resident #156 in the electronic medical record (EMR). She said she would use general fall interventions such as checking on her every two hours, keeping her bed in the low position, decluttering the floor in the room, ensuring the call light was in reach and answering the call light promptly.CNA #4 was interviewed on 9/24/25 at 1:59 p.m. She said she had worked at the facility for three years. She said she was not aware of where to find resident specific fall interventions. She said she would use general interventions such as watching them when they ambulated down the hallway and making sure there was nothing in their path. CNA #4 said Resident #156 was a fall risk before she was admitted to the facility. She said she was no longer a fall risk, she just had poor safety awareness. Unit manager (UM) #1 was interviewed on 9/24/25 at 2:06 p.m. He said he gave a verbal report to the staff on the unit where Resident #156 resided, twice a day. He said he would go over the falls that were discussed by the IDT and provide the staff with updates on fall interventions. UM #1 said some of the interventions he expected were to ensure the resident's door remained open and the staff were rounding every hour. He said the resident specific (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fall interventions were located in the residents care plan and the CNA tasks. He said when reviewing Resident #156's EMR, he said he was unable to locate her specific interventions in the tasks. Registered nurse (RN) #1 was interviewed on 9/24/25 at 2:21 p.m. He said he was new to the unit that Resident #156 was residing on. RN #1 said he checked a resident's tasks for fall interventions because he did not have access to the care plan. The director of nursing (DON) was interviewed on 9/24/25 at 3:30 p.m. She said after a resident had a fall, the IDT reviewed the fall, discussed the prior interventions and why those interventions did not work and added the specifics of the fall to the resident's care plan. The DON said the CNAs and the nurses were notified of new fall interventions when the fall prevention nurse went around and verbally told them. She said she expected the staff to also look in the resident's care plan and tasks because they were updated after every fall. She said she was not aware the staff were unclear on where to find resident fall interventions.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents who were trauma survivors, received culturally competent, trauma-informed care in accordance with professional stands or practice and accounting for the residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for one (#144) of three residents reviewed out of 71 sample residents. Specifically, the facility failed to ensure individualized care approaches were provided for Resident #144 to prevent re-traumatization. Findings include:I. Facility policy and procedureThe Trauma Informed Care and Culturally Competent Care policy, revised August 2022, was provided by the director of nursing (DON) on 9/25/25 at 9:29 a.m. It read in pertinent part, Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. Identify and decrease exposure to triggers that may re-traumatize the resident.II. Resident #144A. Resident statusResident #144, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included cerebral infarction (stroke), post-traumatic stress disorder (PTSD), psychotic disorder not due to a substance or known psychological condition and anxiety.The 9/18/25 minimum data set (MDS) assessment revealed Resident #144 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #144 had no documented behaviors. B. Resident interviewResident #144 was interviewed on 9/24/25 at 9:21 a.m. She said she was scared of the nursing home administrator (NHA) because he entered her room and made himself look taller while raising his voice at Resident #144. She said she filed a grievance and the NHA responded each time, telling her she should find a new place to live since she was not happy at the facility and filed so many grievances. Resident #144 said she did not want to move facilities.C. ObservationsOn 9/24/25 at 9:50 a.m. Resident #144 needed assistance to go to an activity. The NHA said he would assist the resident to the activity. The regional clinic resource told the NHA she would assist the resident to the activity due to the resident having an issue with men. D. Record reviewResident #144's psychosocial care plan, revised 11/15/24, revealed the resident was at risk for decreased psychosocial well-being, adjustment issues, emotional distress, ineffective coping skills and poor impulse control related to a history of being sexually assaulted by a male physician. Interventions included administering medications as ordered and monitoring for side effects, allowing the resident extra time to respond to questions, assisting the resident to normalize feelings so the resident knew she was not alone in her thoughts, experiences, feelings and behaviors, providing behavioral and psychological services as indicated, contacting the resident's representative for comfort and support, encouraging the resident to express emotions, helping the resident identify triggers that prompt symptoms; monitoring for complaints of pain, observing for signs of distress, safeguarding the resident from alleged or suspected abuse perpetrator and transferring to acute care for further evaluation if indicated.Resident #144's trauma-informed care plan, revised 3/24/25, revealed the resident was at risk for decreased psychosocial well-being due to adjustment issues, emotional distress, ineffective coping skills, and poor impulse control because she had a tornado hit her house as a child, she had a work related injury where a microwave fell on her head, a vehicle accident as a child, getting a life threatening illness and the sudden and unexpected death of her mother and uncle. Interventions included allowing the resident time to make choices regarding her care and encouraging active decision making. approaching the resident in a calm, reassuring manner, encouraging family visits and interactions, encouraging relaxation techniques, encouraging the resident to verbalize her feelings, encouraging activities of the resident's choice, monitoring for signs and symptoms of decreased psychosocial well-being; offering pastoral visits as indicated, providing a psychiatry evaluation and treatment as indicated, providing psychological evaluation and treatment as indicated; reorienting and redirecting the resident as necessary; and social services visits as indicated.-The care plan did not provide (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions to address the resident's fear of the NHA III. Staff interviewsThe NHA was interviewed on 9/24/25 at 12:50 p.m. The NHA said he was not aware that the resident was afraid of him, but knew at times she did not like the NHA. He said any time he responded to grievances he brought a female staff with him into Resident #144's bedroom as a witness. The NHA said he did not tell the resident she should move facilities, but asked if she wanted to move facilities because she did not seem happy with where she was. -The facility failed to identify the resident had been sexually abused by a male in power and provide appropriate interventions to address the resident's grievances. Registered nurse (RN) #3 was interviewed on 9/24/25 at 1:07 p.m. RN #3 said Resident #144 had behaviors where she was involved in a family member's care who also resided at the facility. RN #3 said Resident #144's trigger was being educated on anything she did not want to hear. She said she was unaware of triggers involving men or being afraid of men. She said she only knew men were not allowed to provide her care due to her past trauma. Certified nurse aide (CNA) #5 was interviewed on 9/25/25 at 9:54 a.m. CNA #5 said Resident #144 became really anxious if things did not go her way or if she was told no. She said Resident #144 did not have issues with men but preferred females providing her care and CNA #5 said she was unsure why. CNA #5 said it was possibly documented in her care plan but said she was not sure.-The facility failed to ensure the staff caring for Resident #144 were aware of her past trauma. The DON and the regional clinical resource were interviewed together on 9/25/25 at 11:21 a.m. The DON said Resident #144 had behaviors of being accusatory of staff and one time she had expressed she wanted to kill herself, but nothing current. The DON said the resident's triggers were hard to identify but she felt male figures were a trigger. She said the resident's biggest fear was that the NHA would pack up her room and kick her to the curb. The DON said the resident was explained the process for discharging a resident.The regional clinical resource said Resident #144 always had a problem with something and there never seemed to be a resolution that made her feel satisfied. The DON said more education was going to be provided to staff so the staff knew where to find pertinent information like trauma and triggers.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on record review and interviews, the facility failed to provide the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being for one (#130) of three residents reviewed out of 71 sample residents.Specifically, the facility failed to:-Document resident specific care approaches, to include medication specific target behaviors and person-centered interventions for Resident #130; and,-Document attempted non-pharmacological interventions prior to the administration of a as needed (PRN) anti anxiety medication. Findings include:I. Resident #130A. Resident statusResident #130, age greater than 65, was admitted to the facility 8/21/25. According to the September 2025 computerized physician orders (CPO), the diagnosis included cognitive communication deficit and dementia with behavioral disturbances and agitation.The 8/27/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. He required substantial to maximal assistance with toilet hygiene, lower body dressing and partial to moderate assistance with upper body dressing.The MDS assessment indicated the resident did not have any behaviors during the assessment look back period.B. Record reviewThe anti-anxiety care plan, dated 8/22/25, documented Resident #130 used anti anxiety medication related to adjustment issues and agitation. Pertinent interventions included administering anti anxiety medication as ordered, monitoring for side effects and effectiveness, monitor the resident for safety for increased risk of confusion, amnesia, loss of balance and cognitive impairment, monitor and record occurrence of for target behavior symptoms.The psychosocial-behavior care plan, revised on 9/16/25, documented behavioral symptoms included delusions, anxiety and yelling out. The care plan documented Resident #130 had been physically aggressive with staff. Pertinent interventions included administering medication as ordered, anticipating the residents needs and meeting promptly, encouraging the resident to verbalize feelings and maintaining a calm, slow, understandable approach.A second psychosocial-mood care plan, dated 9/16/25, documented the resident was at risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental physical social or spiritual well being related to: other displays of delusions and would threaten staff that he had a gun. Pertinent interventions included administering medications as ordered and monitoring for side effects as indicated, assessing coping strategies and respecting resident's wishes to the extent possible, assisting with conflict resolution as needed, encouraging to voice feelings and frustrations as indicated, observing for tearfulness, increased agitation and decreased participation in care. -Review of the resident's care plan did not reveal person-centered interventions to trial prior to the administration of the PRN lorazepam.The 9/2/25 behavioral health nurse practitioner (NP) progress note, dated 9/2/25, from the documented a new diagnoses of Alzheimer's dementia with psychotic disturbance, Alzheimer's disease with late onset and dementia in other diseases classified elsewhere with psychotic disturbance.A review of the September 2025 CPO revealed the following physician's orders:Lorazepam (Ativan- anti anxiety medication) oral tablet 0.5 milligrams (mg). Give one tablet by mouth every 12 hours as needed for dementia with behavioral disturbance for 14 days, ordered 9/2/25.Lorazepam oral tablet 0.5 mg. Give one tablet by mouth every eight hours as needed for dementia with agitation for 14 day, ordered 9/16/25.-Review of Resident #130's electronic medical record (EMR) did not reveal non-pharmacological interventions that were to be trialed prior to the administration of the PRN lorazepam medication.A progress note, dated 9/4/25 at 4:03 a.m., documented Resident #130 received PRN Ativan for agitation. -There were no non-pharmacological interventions documented prior to the administration of the PRN Ativan. A progress note, dated 9/4/25 at 10:20 p.m., documented Resident #130 received PRN Ativan for being anxious, he tried to walk without assistance and looking for an exit. -There were no non-pharmacological interventions (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented prior to the administration of the PRN Ativan. A progress note, dated 9/7/25 at 11:01 p.m., documented Resident #130 received PRN Ativan for yelling at the staff. Staff attempted to redirect but the resident continued to yell out.-There were no non-pharmacological interventions documented prior to the administration of the PRN Ativan.A progress note, dated 9/12/25 at 7:12 a.m., documented Resident #130 received PRN Ativan for agitation and stated he owned the place and called the staff names. -There were no non-pharmacological interventions documented prior to the administration of the PRN Ativan. A progress note, dated 9/15/25 at 4:15 p.m., documented Resident #130 received PRN Ativan for agitation. -There were no non-pharmacological interventions documented prior to the administration of the PRN Ativan. C. Staff interviewsLicensed practical nurse (LPN) #3 was interviewed on 9/24/25 at 9:35 a.m. LPN #3 said when a resident exhibited behaviors the staff were to document the specific behaviors in the resident's electronic medical record (EMR). She said when a resident was prescribed a PRN psychotropic medication, non-pharmacological interventions should be attempted prior to the administration of the medication, if the non-pharmacological interventions were not successful then the PRN medication would be administered. She said the non-pharmacological interventions that were attempted were documented in the MAR.LPN #3 said she reviewed Resident #130's EMR and was not able to find the non-pharmacological interventions.The director of nursing (DON) and the regional clinical resource (RCR) were interviewed together on 9/25/25 at 8:18 a.m. The DON said a PRN psychotropic was given a 14 day stop date and then then resident would be reassessed to determine if a PRN medication was effective. The DON said the interdisciplinary team (IDT) and medical providers used the behavior monitoring charting and progress notes from the EMR to assess the frequency the medication was administered, what non-pharmacological interventions were used prior to the administration of the medication and the effectiveness of the non-pharmacological interventions and PRN medication. The DON said non-pharmacological interventions should be attempted and documented prior to administering a PRN medication. The DON said the non-pharmacological approaches were found in the EMR and were specific to the resident.The DON and the RCR said they were unable to find the non-pharmacological interventions specific to Resident #130 prior to administering the PRN Ativan.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observations, record review and interviews, the facility failed to implement their policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption on two of four hallways.Specifically, the facility failed to ensure safe and appropriate storage of food items in resident's personal refrigerators. Findings include: I. Professional reference The Colorado Retail Food Establishment Regulations, (3/16/24), retrieved on 9/29/25 read in pertinent part, Except during preparation, cooking, or cooling, or when time is used as the public health control, time/temperature control for safety food shall be maintained at 135 degrees Fahrenheit (F) or above, or at 41 degrees F or less (3-501.16). Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit (F) or less for a maximum of seven days. The day of preparation shall be counted as day one. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (3-501.17). II. Facility policy and procedure The Foods Brought by Family/Visitors policy, dated 5/28/25, was provided by the nursing home administrator (NHA) on 9/22/25 at 11:30 a.m. It read in pertinent part, Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. The dietician, nurse supervisor, or other designee will explain safe food handling practices to family/visitors in a language and format they understand. The dietitian, nurse supervisor, or other designee will provide necessary education to the nursing staff on safe food handling practices and identify where this information is readily available for reference. Nursing staff is responsible for assisting residents to access food brought to the facility and for assisting with the consumption of the food item if the resident is not able to do so independently. The food service or nursing staff may assist with reheating or other preparation activities using safe food handling practices including safe reheating, hot/cold holding, handling of leftovers, and contamination avoidance. Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration for longer than two hours are discarded. III. Resident interview Resident #4 was interviewed on 9/22/25 at 11:54 a.m. Resident #4 said there were only two staff members that checked his refrigerator, and that one night shift nurse checked his refrigerator consistently. IV. Observations On 9/22/25 at 12:00 p.m. the following observations were made in Resident #4's personal refrigerator: (continued on next page)

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Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A clear four ounce container of cottage cheese with a date of 9/12/25; and, -A four ounce container of yogurt with a use by date of 9/18/25. On 9/24/25 at 2:25 p.m. the outdated food items observed on 9/22/25 (see observation above) had not been removed from the refrigerator. V. Staff interviews The NHA was interviewed on 9/25/25 at 4:00 p.m. The NHA said the residents 'personal refrigerators should be monitored by overnight staff, specifically the nurses but the nurses could delegate the task to a certified nurse aide (CNA) to complete the temperatures. VI. Additional resident interviews Resident #14 was interviewed on 9/22/25 at 10:42 a.m. She said the facility staff helped her keep her refrigerator clean. She said that the staff also checked the temperature in her refrigerator. Resident #153 was interviewed on 9/23/25 at 2:56 p.m. He said the staff checked his refrigerator regularly. He asked two unidentified certified nurse aides (CNAs), that were in the hallway, where they logged the refrigerator temperatures, they told him that there is a binder that is kept at the nurse's station. VII. Observations On 9/22/25 at approximately 10:45 a.m. the following was observed in Resident #14's personal refrigerator: -Three thawed Uncrustables, that were not dated. -There was not a thermometer in the refrigerator or freezer. VIII. Record review The Garden unit's personal refrigerator logs for the month of September 2025 were provided by the NHA on 9/25/25 at 1:23 p.m. The temperature logs revealed that the refrigerator temperatures were not being taken constantly. From September first through September 25th there were approximately 12-14 missing temperatures missing on each of the refrigerator logs for the Garden unit. Resident #14's temperature log documented that her refrigerator was new on 9/4/25 and did not have a thermometer. The log indicated from 9/9/25 to 9/13/25it was documented that she still did not have a thermometer. It was documented on the log that the nurse was notified the thermometer was missing on 9/13/25. On 9/17/25 to 9/19/25 and on 9/25/25 the log documented there was not a thermometer in Resident #14's refrigerator. IX. Staff interview Licensed practical nurse (LPN) #5 was interviewed on 9/24/25 at 2:46 p.m. He said the temperatures of the residents' personal refrigerators should be taken by the overnight shift. He said there was a (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	binder at the nurse's station where they were supposed to log the temperatures and if the refrigerator had been cleaned. He said there were some logs that were posted on the resident's refrigerator. He said he was not sure why some logs were kept in different places. He said that the overnight shift was usually the one that helped clean the refrigerators. He said any staff could help clean the refrigerators. He said that Resident #14's family member had brought in her personal refrigerator and had not told any staff members that she was going to bring one in. He said that was why she did not have a temperature log. -However, Resident #14 did have a temperature log. Her refrigerator did not contain a thermometer (see record review above).

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to establish a communication process that included how the communication would be documented between the facility and the provider for two (#11 and #9) of four residents reviewed for hospice care out of 71 sample residents.Specifically, the facility failed to establish a communication process according to the hospice agreement that included documentation of care and services provided by hospice filed and maintained for Resident #11 and Resident #99. Findings include: I. Facility policy and procedure The Hospice Program policy, revised July 2017, was provided by the nursing home administrator (NHA) on 9/25/25 at 9:30 a.m. It read in pertinent part, Our facility has an agreement in place with at least one Medicare-certified hospice to ensure that residents who wish to participate in a hospice program may do so. Hospice providers who contract with this facility must have a written agreement with the facility outlining (in detail) the responsibilities of the facility and the hospice agency; and are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. These responsibilities include the following: Administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care; notifying the hospice about the following such as a significant change in the resident's physical, mental, social, or emotional status, clinical complications that suggest a need to alter the plan of care or a need to transfer the resident from the facility for any condition; and communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day. II. Resident #11 A. Resident status Resident #11, age greater than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included acute respiratory failure, acute kidney failure, heart disease with heart failure and depression. The 8/11/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. She needed substantial assistance with hygiene and toileting and set up for eating and dressing. The assessment documented the resident received hospice care. B. Hospice agreement The hospice agreement for Resident #11's hospice services was provided by the director of nursing (DON) on 9/24/25 at 3:15 p.m. It read in pertinent part, Nursing facility and hospice shall each prepare (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and maintain complete and detailed clinical records concerning each resident hospice patient receiving nursing facility services and hospice services under this agreement in accordance with prudent record keeping procedures and as required by applicable federal and state law and regulations and applicable federal program guidelines. Each clinical record shall completely, prompt and accurately document all services provided to, and events concerning, each residential hospice patient (including evaluations, treatments, progress notes, authorizations to admission to hospice and/or nursing facility and physician orders entered pursuant to this agreement. Nursing facility and hospice shall cause each entry made for services hereunder to be signed by the person providing the services. C. Record review Resident #11's hospice care plan, initiated 8/11/25, documented she had a terminal prognosis related to a diagnosis of acute respiratory failure and received hospice care provided by a local hospice provider. Pertinent interventions, initiated 8/11/25, included working cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met, adjust the provision of activities of daily living (ADL) to compensate for the resident's changing abilities and encouraging participation to the extent the resident wished to participate. Resident #11's skin impairment care plan, initiated 8/13/25, documented she had actual impairment to skin integrity related to wounds to her right and left lower extremities, sacrum and the need for treatment. Pertinent interventions, initiated 8/13/25, included following the facility's protocols for the treatment of injury and to monitor and document the location, size and treatment of skin injury and reporting abnormalities, failure to heal, signs and symptoms of infection, and maceration to the physician. -However, Resident #11's comprehensive care plan did not document what care was to be completed by the hospice provider and when. A review of Resident #54's February 2024 CPO revealed the following physician orders: admitted to hospice care prior to admission, ordered 8/20/2025. Resident #11's hospice binder was retrieved from the nurses' station and provided by licensed practical nurse (LPN) #1 on 9/24/25 at approximately 6:20 p.m. The hospice binder contained weekly visit verification forms. The binder had three hospice visits documented as routine visits on 8/8/25, 8/25/25 and 8/29/25. A review of Resident #11's electronic medical record (EMR) revealed an 8/18/25 hospice note by an RN with routine care. -However, the 8/8/25 hospice note did not include documentation of the staff who completed the routine visit. The 8/18/25, 8/25/29 and 8/29/26 hospice notes were signed by a registered nurse (RN) but did not include any care or assessments provided. No other hospice visit notes were in the resident's EMR. Resident #11's hospice notes were provided by the DON on 9/25/25 at approximately 9:30 a.m. and uploaded into Resident #11's EMR (during the survey). A review of the hospice notes revealed the following visits documented by hospice staff: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A chaplain visit on 8/28/25 declined by Resident #11 due to scheduling conflicts. A certified nurse aide (CNA) completed visits on 8/28/25, 9/2/25, 9/4/25, 9/9/25, 9/16/25, 9/18/25 and 9/23/25 that included the following completed care planned interventions: Apply moisturizing lotion to skin Tuesdays and Thursdays; assist with oral care Tuesday and Thursday, and bed bath and shampoo Tuesday and Thursday. An LPN visit completed 8/15/25, 8/22/25, 9/15/25. The 9/15/25 LPN visit documentation included the following assessments and care provided: vital signs, respiratory breath sounds and wound care was completed according to the resident's care plan. Social worker visits completed on 8/15/25, 8/28/25, 9/11/25. A registered nurse (RN) completed visits on 8/18/25, 8/25/25, 8/29/25, 9/4/25, 9/8/25, 9/10/25, and 9/19/25. The 9/4/25 RN visit note documented wound care was completed according to the care plan for the resident's right and left leg wounds. D. Staff interviews The DON was interviewed on 9/25/25 at 11:00 a.m. The DON said the hospice company checked out with her after visits. The DON said the hospice company would also usually check out with the unit manager if they came in. The DON said the notes were usually provided on a week or two week basis. The DON said the notes were sent to the facility and she/the DON would upload them in the chart. III. Resident #9 A. Resident status Resident #9, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, diagnoses included subacute osteomyelitis (bone infection), quadriplegia, type two diabetes and pressure-induced deep tissue damage. The 9/2/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The assessment revealed that he was dependent on staff for most of his ADLs. B. Record review Resident #9's hospice care plan, initiated 2/21/25, documented he had chronic osteomyelitis and received care from a local hospice provider. Pertinent interventions, initiated 2/21/25, included working cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met, o things like ice cream, sherbet, milk shakes, more often and focus on potential pleasure foods, allowing the resident one beer a day for his pleasure, adjusting provision of ADLS to compensate for the residents changing abilities and encourage participation to the extent the resident wishes to participate. Review of Resident #9's EMR revealed hospice notes from March 2025 through the middle of July 2025 and the hospice care plan (from the hospice provider) were missing from his EMR. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Staff interviews LPN #6 was interviewed on 9/25/25 at 9:35 a.m. She said there was a hospice communication book/binder for each resident that was on hospice services. She said the hospice book/binders were used mostly for the hospice employees to communicate with each other. She said she would use the book/binder every once in a while to see which hospice certified nurse aide (CNA) had given Resident #9 a bath. She said the hospice team communicated with the facility nursing staff verbally. She said that the facility staff could call the hospice phone number if they had any questions. She said that she did not look at the hospice notes that are uploaded into the EMR. The DON was interviewed on 9/25/25 at 1:47 p.m. She said that Resident #9's hospice care plan (from the hospice provider) should have been uploaded into the EMR. She said the hospice team would email hospice notes either weekly or biweekly to a facility email. She said sometimes the hospice team might email the notes directly to medical records. The DON was interviewed again on 9/25/25 at 1:55 p.m. She said she had received Resident #9's notes from the hospice provider.