STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065404	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sloan's Lake Rehabilitation Center	1601 Lowell Blvd Denver, CO 80204

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease on 2 out of 2 units. Specifically, the facility failed to ensure staff donned (put on) the appropriate personal protective equipment (PPE) when providing care to residents who were on enhanced barrier precautions. Findings include: I. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 4/2/24, retrieved on 3/9/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high-contact resident care activities. Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident to resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of a gown and gloves for high-contact resident care activities is indicated when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices, regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (ex. central line, urinary catheter, feeding tube, tracheostomy/ventilator), or wound care (any skin opening requiring a dressing). In general, gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to standard precautions. Residents are not restricted to their rooms or limited from participation in group activities. Because enhanced barrier precautions do not impose the same activity and room placement restrictions as contact precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.II. ObservationsOn 3/2/26 at 4:20 p.m., the director of nursing (DON) and registered nurse (RN) #1 entered the room to access Resident #17's peripheral inserted central catheter (PICC) to flush and cap. The DON and RN #1 had gloves on. -The DON and RN #1 failed to don a gown prior to provide care to Resident #17 who required EBP related to a PICC line and wounds. On 3/4/26 at 2:50 p.m.Resident #85 was assisted to his room by a physical therapist and certified nurse aide (CNA) #9. CNA #9 and the physical therapist put on gloves. They transferred Resident #85 from his wheelchair to his bed. The physical therapist and CNA #9 proceeded to change his undergarments, which were soiled. -The physical therapist and CNA #9 failed to don a gown before providing incontinence care. III. Staff interviewsRN #1 was interviewed on 3/3/26 at 11:20 a.m. She said the staff needed to wear a gown and gloves when providing care to a resident who was on EBP.The DON was interviewed on 3/3/26 at 11:28 a.m. The DON said the importance of (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBP was to prevent the spread of infection. She said the staff should have worn a gown and gloves when caring for Resident #17.The physical therapist was interviewed on 3/4/26 at 2:56 p.m The physical therapist said when a resident was on EBP they needed to wear gloves when providing care. CNA #9 was interviewed on 3/4/26 at 3:05 p.m CNA #9 said enhanced barrier precautions were to wear a gown, gloves, and a mask. LPN #2 was interviewed on 3/4/26 at 3:20 p.m. LPN # 2 said the staff needed to have a gown and gloves on for resident care. LPN #2 said the staff should have worn PPE when assisting Resident #85.