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	09/16/2022

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47222 Based on record review, observation, resident and staff interviews the facility failed to promote privacy while providing incontinence care when the resident's privacy curtain did not provide full privacy. This occurred for 1 of 1 resident (Resident #117) reviewed for incontinence care. Findings included: Resident #117 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #117 was cognitively intact. During an interview with Resident #117 on 9-12-22 at 9:32am, the resident stated she was concerned about her privacy because her privacy curtain did not extend all the way around. The resident stated she had reported the issue to a nurse but could not remember the nurse's name. Observation of the privacy curtain occurred on 9-12-22 at 9:32am. The observation revealed the curtain was not wide enough to extend all the way around the resident exposing either the resident's roommate window which had the blinds pulled up or the door while staff performed care to Resident #117. The Environmental Services Manager was interviewed on 9-13-22 at 2:34pm. The Environmental Services Manager stated they were responsible for hanging the privacy curtains in the resident rooms and making sure the curtain covered the whole area to provide privacy for the resident. The Environmental Service Manager observed Resident #117's privacy curtain and confirmed the curtain was not wide enough to provide full privacy for Resident #117. She stated she was unaware of the issue and explained issues were reported to her by word of mouth usually from the nurse. An interview with a Certified Nursing Assistant (CNA) #4 occurred on 9-13-22 at 2:43pm. The CNA stated he was aware of Resident #117's privacy curtain not providing full privacy during care. He said he had reported the issue to a nurse about a month ago but could not remember what nurse he had reported the issue to and did not know if the nurse reported the issue to maintenance. LPN #6 was interviewed on 9-13-22 at 2:50pm. The LPN discussed not being made aware of Resident #117's privacy curtain not providing the resident full privacy. She stated if she had been aware of the issue, she would have documented the issue on the maintenance log or paged maintenance over head to come and assess the issue. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was interviewed on 9-13-22 at 3:13pm. The DON stated she was not aware of Resident #117's privacy curtain not extending enough to provide full privacy. She stated the resident would have contacted the Unit Manager (RN #5) if there were an issue and the Unit Manager would have resolved the issue. The DON stated she would speak with housekeeping to see if there was a longer privacy curtain available. During an interview with RN #5 on 9-13-22 at 3:22pm, RN #5 stated she had not been made aware of Resident #117's privacy curtain not providing full privacy during care. She stated she would enter the issue into the maintenance computer system. The Administrator was interviewed on 9-13-22 at 3:38pm. The Administrator stated Resident #117 had not voiced any concern about her privacy curtain not providing full privacy during care. He explained if he had known about the issue, he would have had the issue corrected and expected all residents to have full privacy while being provided care.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45554 Based on observations, interviews, and record reviews, the facility failed to complete a Level II Preadmission Screening and Resident Review (PASRR) when Resident #17 was diagnosed with a new mental illness. This deficient practice affected Resident #17, 1 of 3 sampled residents reviewed for PASRR. Findings included: Review of Resident #17's Colorado Pre-Admission and Resident Review Program Level I Identification Screen dated 10/16/2017, revealed there was no major mental illness or psychiatric diagnosis identified for the resident. A review of Resident #17's Admission Record revealed the facility admitted Resident #17 on 05/30/2018. According to the Admission Record, on 12/16/2019, the resident received new diagnoses of depressive episodes and post-traumatic stress disorder (PTSD). Review of a quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #17 had a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. During an observation and interview on 09/12/2022 at 1:07 PM, Resident #17 was in bed in his/her room. Resident #17 stated he/she was happy with the care received at the facility, that the medications helped with his/her anxiety, and that the staff were very supportive. During an observation on 09/15/2022 at 3:33 PM, Resident #17 was sitting in a wheelchair in his/her room. The resident was clean, calm, neat in appearance, and had a pleasant demeanor. During an interview with the Director of Social Services (DSS) on 09/13/2022 at 2:43 PM, she stated she had been at the facility since 08/10/2022 and, when residents were admitted to facility, a Level I PASRR I evaluation was completed if one was not completed prior to admission. According to the DSS, PASRR screenings were used to evaluate whether a resident could receive the appropriate level of care while in the facility. The DSS stated she looked at the PASRR to see if a resident had a diagnosis of trauma, including PTSD, anxiety, depression, schizoaffective disorder, bipolar disorder and any severe and persistent mental illness or developmental disability. Per the DSS, PTSD was a diagnosis that would be included in the PASRR screening. The DSS reviewed Resident #17's Level I PASRR dated 10/16/2017 and stated the diagnosis of PTSD was not addressed. According to the DSS, a new Level II PASRR should have been completed for Resident #17 when there was a new diagnosis of PTSD in 2019. The DSS confirmed there was no Level II PASRR completed after the resident received a new mental illness diagnosis. The DSS stated she could not offer a reason as to why a Level II PASRR was not completed for Resident #17, as she was not an employee of the facility during the time the resident received the new diagnosis. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 09/14/22 at 10:18 AM, she stated when a resident had a new mental illness diagnosis, the DSS should initiate a Level II PASRR screening. Per the DON, if the screening was not completed as needed, the facility may not be able to meet the resident's needs. According to the DON, Resident #17 had psychiatric services routinely, had not had any issues with behaviors, and was stable at this time. The DON reported the previous DSS was responsible for the PASRR, and she could not say why the Level II PASRR screening was not done for Resident #17. The DON also acknowledged the facility did not have a policy to address the PASRR. During an interview on 09/15/2022 at 2:17 PM, the Administrator stated it was expected that after a new mental illness diagnosis, there was a Level II PASRR screening completed for the resident, to ensure the facility could give the resident the needed care and services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 42883 Based on interviews, record review, and facility policy review, the facility failed to supervise residents that required supervision while smoking, ensure residents assessed to wear a smoking apron were provided one, and failed to ensure independent and supervised residents had a safe place to discard cigarette butts after smoking for 3 of 3 residents reviewed for smoking (R #110, R #74, and R #21). Failed to ensure Resident #74 smoked in designated area, and used the trash can It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The IJ began on 09/12/2022 when Resident #21 was observed unsupervised while smoking, without wearing a smoking apron, and threw a lit cigarette into a trash can. The Administrator and DON were notified of the IJ on 09/12/2022 at 7:02 PM and provided the IJ Template at 7:03 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 09/14/2022 at 5:22 PM. The IJ was removed on 09/16/2022 at 9:50 AM after the survey team performed onsite verification that the Removal Plans had been implemented. Noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that was not immediate jeopardy for F689. Findings include: The facility policy, OPS131/Smoking Policy, revised on 11/20/2018, revealed, For centers that allow smoking, smoking will be permitted in designated areas only. Patients will be assessed upon admission, quarterly, a change in condition, for the ability to smoke safely and if necessary, with supervision. The policy indicated 2.2.1 An area as a smoking area will be environmentally separate from all patient care areas (e.g., outdoors or a smoking lounge), will be well ventilated, and, if outdoors, will protect patients from weather conditions. 2.1.4 Ashtrays made of non-combustible materials and safe design, and metal containers with self-closing covers into which ashtrays can be emptied, shall be provided in all designated smoking areas as well as at all entrances. 2.3 The admitting nurse will perform a Smoking Evaluation on each patient who chooses to smoke. 2.3.1 Patients will be re-evaluated quarterly and with a change in condition. 2.5 A patient's smoking status-independent, supervised, or not permitted to smoke-will be documented in the care plan. 2.6 Smoking supplies (including, but not limited to, tobacco, matches, lighters, lighter fluid, etc.) will be labeled with the patient's name, room number, and bed number, maintained by staff, and stored in a suitable cabinet kept at the nursing station. 2.6.1 Patients will not be allowed to maintain their own lighter, lighter fluid, or matches. 2.7 Center leadership will consider special circumstances on an individual basis (e.g., the need for a smoking apron and/or flame retardant clothing. 1. A review of Resident #21's Admission Record revealed the resident had diagnoses of atherosclerotic heart disease, vascular dementia with behavioral disturbance, muscle weakness, polyneuropathy, dysphagia, and lack of coordination. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident #21 had a Brief Interview for Mental Statis (BIMS) score of 9, indicating moderately impaired cognition. The MDS revealed Resident #21 required limited assistance of one person with bed mobility, transfer, toileting, and personal hygiene; and was independent with eating. According to the MDS, Resident #21 had no behaviors, and did not reject care that was necessary to achieve the resdient's goals for health and well-being. Indicated utilized oxygen while a resident of the facility and within the last 14 days. A review of Resident #21's care plan revised 05/11/2022 revealed the resident was resistive to care related to being noncompliant with supervised smoking times. The care plan indicated Resident #21 would get cigarettes from other residents. The goal was for Resident #21 to ask for staff assistance when going out to smoke. The facility developed interventions that included evaluating the nature and circumstances of the resistive behavior; encouraging participation in identified special treatment programs; providing a consistent, trusted caregiver and structured daily routines, when possible; explaining all care; and providing for opportunities for choice during care/activities to provide a sense of control. Continued review of Resident #21's care plan revised on 05/11/2022 revealed the resident may smoke with supervision per the resident's smoking assessment. Interventions included educating the resident on the facility's smoking policy, informing of and reinforcing smoking restrictions, reassessing the residents ability to smoke with supervision with any change in condition, providing a smoking apron if indicated, supervising the resident with smoking in accordance with the resident's assessed needs, ensuring there was no oxygen in use in the smoking area, ensuring appropriate cigarette disposal receptacles were available in smoking areas, monitoring residents compliance with the smoking policy, and maintain residents' smoking materials at the nurses' station. A review of Resident #21's Smoking Evaluation dated 08/02/0222 revealed had dementia, had a history of unsafe smoking habits, had a history of sharing/selling cigarettes or smoking material. According to the evaluation, Resident #21 could safely hold a cigarette, had the ability to light a cigarette, properly disposed of ashes or butts, and could smoke safely without use of a smoking apron. According to the evaluation, supervised smoking was required for Resident #21. Observation was conducted on 09/12/2022 at 3:45 PM of Resident #21 placing a lit cigarette into the trash can in the smoking area. Resident #21 was not wearing a smoking apron, and there were no staff in the line of sight of the smoking area or the resident. Observation revealed there were several burn holes in the resident's yellow sweatpants. An observation and interview on 09/12/2022 at 4:21 PM with Resident #21 revealed the resident was sitting in a wheelchair in the hallway wearing yellow sweatpants and a dark colored sweatshirt. Observation revealed there were also visible burn holes on the front of the resident's shirt. Resident #21 stated he/she smoked in the morning and afternoon. The resident stated staff did not ask the resident to wear an apron while smoking, and staff did not remain outside while the resident smoked. Resident #21 stated he/she lit his/her own cigarettes. The resident pulled out a blue lighter from his/her pocket and grabbed an object in the other pocket and stated that was his/her pack of cigarettes. Further interview with Resident #21 revealed the resident stated the holes in his/her sweatshirt was burn holes from cigarette ashes falling on the resident's clothing while smoking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 09/13/2022 at 1:40 PM with Licensed Practical Nurse (LPN) #1 revealed a resident smoking schedule was located on the Garden Unit that listed smoking times and the staff member assigned to supervise the smoke break. LPN #1 stated the schedule listed a hall number and the Certified Nursing Aide (CNA) assigned to that hallway was required to monitor the residents while they smoked. According to LPN #1, Resident #21 let staff know when he/she wanted to go outside to smoke, and there should never be a resident smoking without a staff member aware or present to monitor. LPN #1 stated both independent and supervised smokers followed the same smoking schedule, and all the cigarettes and lighters were kept secured in a cart and labeled with the resident's name at the nurse's station. LPN #1 stated there were no residents that she was aware of that kept their cigarettes or lighter with them. LPN #1 stated she when she was alerted that Resident #21 threw a lit cigarette into the trash can outside, she, Registered Nurse (RN) #4 and another staff member ran outside and retrieved the cigarette from inside the trash can to extinguish it. LPN #1 stated she saw several staff members standing outside in the smoking area wearing black scrubs, but she was unsure who the staff were, and she did not try to speak to any of them about the situation. According to LPN #1, there were no other residents outside. Further interview with LPN #1 revealed she was unsure where the list was located that indicated which residents required supervision with smoking. Subsequently, she did not know which residents required supervision and which did not. An observation and interview on 09/13/2022 at 2:41 PM with the Assistant Dietary Manager (ADM) revealed the ADM was smoking in the designated smoking area where residents also smoked. The ADM confirmed that staff smoked in the same designated smoking areas as the residents. The ADM stated he was usually outside on a smoke break four to five times during his shift, but he was not familiar with smoking protocol. The ADM stated he believed there were some residents that required supervision while smoking, but he did not observe staff supervising residents during smoke times and he had not seen that occur for about two years. However, the ADM stated when he was outside smoking, he had no way of knowing which resident required supervision when smoking or which were independent unless he personally knew the resident. Continued interview with the ADM revealed most residents kept their lighters and cigarettes with them and lit their own cigarettes without staff supervision. According to the ADM, there used to be specific smoking times for residents, usually after a meal because he remembered staff assisting residents to smoke. However, the ADM stated that currently, residents smoked at all times during the day, and there usually was not any a staff member monitoring the resident. He stated staff may be smoking while in the designated smoking areas but were not monitoring residents for safety while they were smoking. The ADM stated he was not sure why the process to supervise smoking residents stopped being enforced, and he stated he had not seen a silver smoking apron on a resident in about two years. The ADM stated he had voiced concerns about the safety of residents who smoked to staff in the past but not recently. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 09/13/2022 at 3:13 PM with RN #4 revealed she was a unit manager on the Garden Unit. RN #4 stated a smoking list was kept at the nurses' station at the front of the staff schedule book. The smoking list had smoking times for the residents on the Garden Unit and listed a hall number that indicated which CNA was responsible for supervising each smoke break. RN #4 stated all residents who smoked were supposed to smoke during the designated times unless a resident who had behaviors had an intervention to offer a cigarette. RN #4 stated she was aware that residents were allowed to smoke on their own in the past and were allowed to keep their own cigarettes and lighters. The RN stated there were still some residents who kept their own cigarettes and lighter, but other residents needed staff to provide them. According to RN #4, when staff observed a resident go outside to smoke, staff had to go with them to monitor the resident. RN #4 also stated staff knew which residents required supervision because they had to request to smoke since staff had to provide their cigarettes and a lighter. RN #4 stated she was not familiar with Resident #21 and did not know if the resident required supervision. RN #4 stated a surveyor alerted her when Resident #21 dropped a lit cigarette in the trash can. She said she went out to the trashcan to retrieve the lit cigarette. RN #4 stated she did not remember if there were any staff present in the smoking area because she never thought to see what staff allowed Resident #21 to leave the smoking area before extinguishing the cigarette. RN #4 also stated smoking aprons were kept in the medication room on the Garden Unit, but those were only for the residents who lived on that unit. She stated residents from other units would need to bring smoking aprons with them from their unit. Further interview with RN #4 stated revealed Non-Certified Nursing Aide (NCNA) #1 assisted residents outside for the smoke break on 09/12/2022 at 3:30 PM. The RN stated she expected staff to remain outside during the entire smoke break. According to RN #4, she did not know which residents were smoking safely since she was not familiar with the residents from other units. She stated staff would intervene if they observed something obviously unsafe, but otherwise staff would not know which residents required supervision from other units in the facility. An observation and interview on 09/13/2022 at 4:52 PM with Registered Nurse (RN) #4 revealed the medication room located on the Garden Unit had two smoking aprons, and another smoking apron was located at the nurse's station. RN #4 stated there were no more smoking aprons that she was aware of. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/14/2022 at 1:16 PM, NCNA #1 revealed there was a smoking schedule with a list of smoking times, and the staff scheduled to monitor each time was on a board located at the nurse's station on the Garden Unit. NCNA #1 stated the facility was provided a handwritten list of residents who smoked who required staff supervision, but she did not have the list anymore. NCNA #1 stated she got rid of the list after she became familiar with the residents on the garden unit. NCNA #1 stated there were residents who smoked who lived on other units, but the provided list of residents did not identify what type of supervision residents from other units required. She states she assumed the list of times located on the board was only for the residents on the Garden Unit, but she had never asked for clarification. NCNA #1 stated that on Monday, 09/12/2022, she was responsible for monitoring the smoke break at 1:30 PM and 3:30 PM. NCNA #1 stated she had observed residents from other units smoking during the Garden Unit smoke times, but she was not sure what level of supervision those residents required, and she had never seen aides from other units supervising residents while smoking. NCNA #1 stated staff got the residents together about five or ten minutes before the scheduled time by asking the residents on the Garden Unit if they wanted to go outside to smoke. NCNA #1 stated there were four residents that smoked who lived on the Garden Unit. NCNA #1 stated she provided the cigarettes and lighter to each resident, lit all the residents' cigarettes for them, and then took the finished cigarette and extinguished it for the resident. Further interview revealed NCNA #1 did not typically provide the residents anything else during their smoke break. NCNA #1 stated she tried to get residents to wear a smoking apron, but not all the residents complied and allowed those residents to smoke without the apron. NCNA #1 stated she was not familiar with Resident #21 and was not in the smoking area when Resident #21 placed a cigarette in a trach can. Further interview with NCNA #1 revealed all residents who smoked independently were allowed to keep their cigarettes and lighters and she had never been instructed otherwise. NCNA #1 stated she had observed some of the independent residents going to the smoking area that day. NCNA #1 stated independent smokers did not adhere to the smoking times, and she had never been instructed to ensure all residents smoked during the scheduled times. NCNA #1 also stated she had never received any training about the smoking protocol, and all her knowledge came from asking questions during her orientation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 09/14/2022 at 4:10 PM with the Director of Nursing (DON) revealed staff were The DON stated staff received training related to the smoking protocol about six to twelve months ago. all residents were assessed upon admission for smoking status. Each unit had a list of residents at the nurses' station who smoked. The list also indicated which residents required supervision and which were independent. The DON stated that each unit was responsible for supervising their residents during smoke breaks, and those units had their own designated smoke times. The DON stated there were carts with cigarettes, lighters, and smoking aprons stored on a cart on the Garden Unit and assumed they could also be found on the Evergreen Unit also had a cart, and she assumed there were also smoking aprons stored there. The DON stated there were no residents who smoked who lived on the Arbor Unit. Only one resident who smoked, Resident #21 lived on the Aspen Unit, and the DON stated she was not sure where Resident #21's smoking supplies were stored. According to the DON, Resident #21 was considered an independent smoker and the resident did not require a smoking apron. The DON stated CNAs were required to escort residents who needed supervision to the smoking area, provide their cigarettes, and light the cigarette for the resident. The CNA was required to remain with the residents for the entire break. The DON stated CNA staff were also required to either assist the residents with extinguishing the cigarette or observe the resident extinguishing the cigarette in the correct receptacle. Further interview revealed residents who were assessed to smoke independently were allowed to smoke at different times. The resident was supposed to ask staff to provide them with their cigarettes and lighter. The DON stated residents should not have been allowed to keep their lighters and cigarettes on them. The DON did state that residents that required supervision were required to wear a smoking apron when smoking, but if a resident refused they still allowed the resident to smoke with staff supervision. Staff would notify the responsible party about the refusal. The DON also stated there was a chance that staff may not know which residents required supervision or were independent. She was aware of the incident when Resident #21 threw a lit cigarette into the trash can. When provided with documentation that Resident #21 was a supervised smoker, the DON stated she would have expected staff to be outside supervising Resident #21 during smoke breaks. The DON was also provided documentation by corporate nurse there was only one smoker list for all smokers located on the Garden Unit and only staff from that unit supervised smoke breaks. An interview on 09/15/2022 at 4:43 PM with the Administrator revealed there were supervised and independent residents and a list of smoking times. Administrator stated any residents that required supervised smoke breaks should have been offered smoking aprons and assisted by staff, but the independent residents were allowed to be unsupervised when smoking and light their own cigarettes. Administrator stated he was not sure if the independent residents were able to keep their cigarettes and lighter or if staff had them stored somewhere. Administrator stated residents were only supposed to smoke in designated areas. If staff became aware of a resident smoking in a nonsmoking area, they were supposed to intervene. Administrator stated staff should have remained with Resident #21 until after staff properly disposed of the cigarette butt for the resident. Administrator stated there were designated smoke times for all independent and supervised smokers, and staff were only required to supervise if there was a resident smoking who required supervision. Administrator also stated residents should not have been allowed to keep their lighters and he was aware that some residents had them in their possession. However, if staff asked the resident to give them their lighter and the resident refused, staff would only educate the resident but allow them to keep it. Administrator stated he expected all smokers to properly dispose of cigarette butts in proper receptacles. Administrator further stated he was unaware that Resident #21 was assessed to be a supervised smoker and he thought Resident #21 was independent. He did not know that Resident #21 kept their own cigarettes and lighter and the resident should not have been allowed to do so. Administrator stated the facility policy stated residents should not have been allowed to keep their lighter in their possession. (continued on next page)

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	065238	A. Building B. Wing	09/16/2022

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Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	F-689-Free of Accident Hazards/Supervision/devices Corrective Action: 1. Nurse Manager and/or designee completed a smoking assessment on RI #110, RI #74, and RI #21 on September 12, 2022 and revised the plan of care to include supervised smoking and q15 min checks for 24 hours. 2. RI #110, RI #74, and RI #21 were placed on supervised smoking on September 12, 2022. Supervised smoking consist of direct staff observation during smoking times. 3. Social Service Director and/or designee re-educated RI #110, RI #74, and RI #21 on the Smoking Policy and Procedure on September 12 202. Education included adherence to the smoking times, smoking allowed only with staff supervision, smoking in designated smoke areas, smoking aprons, discarding of cigarette butts, and turning in cigarette paraphernalia to Nursing. A Behavior Contract was initiated with RI #110, RI #74, and RI #21 to acknowledge and obtain written agreement to smoke only in designated smoke areas, dispose of cigarette butts in fire receptacles, adhering to smoke times, and wearing smoking aprons if needed. 4. Licensed Nurse (s) implemented enhanced monitoring consisting of every 15 minute checks of RI #110, RI #74, and RI #21 on September 12, 2022 until September 13, 2022. One on one supervision will be implemented as needed to maintain resident safety. 5. Administrator and/or designee conducted a room search of RI #110, RI#74, and RI #21 to search for and confiscate cigarette paraphernalia. Cigarette lighters were retrieved and placed in a secure (locked) storage cart on Evergreen unit. Only Nursing and/or Ancillary staff will have access to the storage cart. 6. Effective September 13, 2022, designated smoking times will be implemented for all residents who smoke. 7. Maintenance Director and/or designee placed signage on the trash can in the smoking area on September 13, 2022 for trash only. 8. Administrator hosted an Ad Hoc Quality Assurance Performance Improvement meeting with Medical Director engagement on September 12, 2022 to discuss Smoking Policy and specific emphasis on supervision of residents during smoking times, application of smoking aprons, adherence to smoking areas, discarding cigarette butts in fire receptacles, and reporting observations of non-compliance. Version 4 F 689 Identification: 1. Nurse Managers and/or designee completed a new smoking assessment on all residents identified as smokers on September 13, 2022 and revised the plan of care as needed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Interdisciplinary Team thoroughly checked resident rooms to ensure all smoking materials have been confiscated and securely place in the supervised smoking compartment on September 13, 2022. Any resident who would not relinquish cigarette paraphernalia on September 13, 2022 was placed on one to one supervision until materials were confiscated and secured. 3. Interdisciplinary Team thoroughly checked clothing for all resident identified as smokers to ensure no holes or burns were observed on September 13, 2022. No additional concerns were identified 4. Maintenance Director completed an audit of the smoking area on September 12, 2022 to validate availability of smoking blanket, fire receptacles, and fire extinguishers. Effective September 13 2022, smoking aprons will be located in the designated smoking storage cart. 5. Maintenance Director and/or designee validated no smoking signage is posted in non-smoking areas on September 12, 2022. Systematic Measures: 1. The Nurse Practice Educator or designee re-educated Nursing, Social Services, Housekeeping, Dietary, Therapy, and Maintenance employees on the Smoking Policy and Procedure beginning September 12, 2022 with emphasis on designated smoke times, supervision of residents during smoking times, application of smoking aprons, adherence to smoking areas, discarding cigarette butts in fire receptacles, and reporting observations of non-compliance. Any employee on leave of absence (FMLA), vacation, or PRN will be re-educated prior to returning to duty. 2. On September 13, 2022, Social Service Director and/or designee re-educated residents identified as smokers on adherence to the Smoking Policy to include: smoking only in designated smoke areas, designated smoke times, smoking aprons, discarding of cigarette butts, and turning in cigarette paraphernalia to Nursing. 3. Effective September 13, 2022, designated smoking times will be implemented for all residents who smoke. Cigarette paraphernalia and smoking aprons will be stored in a secure designated smoking storage cart. Additionally, documentation outlining individualized safety measures will be based on the smoking assessment and located on or inside the storage cart. 4. Effective September 13, 2022, Director of Nursing and/or designee will review new admissions during the Clinical Meeting to identify smokers and validate a smoking assessment has been completed and a plan of care is in place to maintain resident safety. 5. If a resident is observed as being non-compliant with supervised smoking, a care plan meeting will be scheduled with resident and/or legal representative. Smoking privileges may be revoked. Any further non-compliance may result in the issuance of an immediate discharge notice and/or a 30-day notice for discharge if the residents clinical or behavioral status or condition endangers the safety of individuals within the facility. Quality Assurance and Monitoring: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Nurse Managers and/or designee will randomly observe smokers during smoking times on each shift 3x a week for four weeks, 2x a week for four weeks, and weekly for four weeks to ensure supervision of smokers, validate smoking is occurring in the designated smoke areas, application of smoking aprons, and disposal of cigarette butts in the appropriate receptacle. 2. Maintenance Director or designee will inspect the smoking area 2x a day to ensure and all safety items remain in place. Version 4 F 689 3. Administrator hosted an AD HOC Quality Assurance Performance Improvement (QAPI) meeting on September 12, 2022 with Department Managers and reviewed with the Medical Director on the center's Smoking Policy and the performance improvement measures outlined in this document. Verification of AOC: Review of smoking eval dated 9-12-22 #110, #74, & #21 were completed. All evals indicated supervision while smoking was req. Review of care plan #110, #21 & #74 revealed it was revised to include education on smoking policy, supervised smoking & q shift x24 hours. No revisions. Review #110, #74, & #21 care plans and smoking assessments revealed residents were supervised smokers. Review of Resident Inservice 9-13-22 Cigarette & Smoking policies revealed R#110, #74 & 21 were present during the in-service. Review of signed Behavior Contracts related to smoking policy were signed by #110, #74 & #21. Review of Q-15 check log revealed R#110, #74 & R#21 were completed every 15 minutes for 24 hours starting on 9-12-22. Review of doc room search was completed on 9-12-22 for #110, #74 & #21 revealed were searched and cigarette paraphernalia was confiscated if found. Review of smoke times for all unit's revealed set smoking times. Observation of trash can revealed green sign with black lettering that stated, trash only. Review of AdHoc QUAPI Smoking meeting occurred on 9-12-22 related to smoking policy. Review of 26 resident smoking assessments completed on 9-13-22. Review of Smoking-room search dated 9-13-22 revealed all rooms checked for smoking paraphernalia. Review of clothing search dated 9-13-22 revealed all rooms checked for clothing with holes or burn marks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of smoking area audit dated 9-12-22 (6p-6a), 9-13-22 (6a-6p), 9-13-22 (6p-6a), 9-14-22 (6a-6p), 9-14-22 (6p-6a), 9-15-22 (6a-6p). All fire safety items were available. Observation of in and around smoking area revealed smoking signs were located throughout. Interviews and observations of staff Smoking Policy and Procedure training log started on 09/12/22 revealed 121 nursing staff, 2 administrative staff, 5 physicians, 6 business office staff, 4 activities staff, 17 housekeeping staff, 3 social services staff, 15 dietary staff, 16 rehab staff and maintenance staff completed the training. Review of Resident Inservice 9-13-22 Cigarette & Smoking policies revealed 18 res were in attendance. Review of smoke times for all unit's revealed set smoking times posted. Review of admission review revealed no new admissions to reassess. Review of Resident Inservice 9-13-22 Cigarette & Smoking policy revealed smoking residents made aware of the policy and how facility will address noncompliance. Review of smoking audits revealed smoking observations were completed at least once each shift. Review of smoking area audit dated 9-12-22 (6p-6a), 9-13-22 (6a-6p), 9-13-22 (6p-6a), 9-14-22 (6a-6p), 9-14-22 (6p-6a), 9-15-22 (6a-6p). Review of AdHoc QUAPI Smoking meeting occurred on 9-12-22 related to smoking policy. 28196 2. A review of an Admission Record revealed Resident #74 had diagnoses which included chronic obstructive pulmonary disease, anxiety disorder, and dependence on supplemental oxygen. A review of Resident #74's care plan revealed an intervention dated 01/25/2019 that directed staff to reassess the patient's ability to smoke with supervision with any change of condition. The care plan also directed staff to ensure that appropriate cigarette disposal receptacles were available in the smoking area. A review of Resident #74's Smoking Evaluation (SNF) [skilled nursing facility] form, dated 07/06/2022, revealed the resident could demonstrate the location of the designated smoking area, had no history of unsafe smoking habits, had no history of fire setting or arson, properly disposed of ashes or cigarette butts, smoked safely without the use of a smoking apron, and was allowed to smoke independently. A review of Resident #74's quarterly Minimum Data Set (MDS) assessment, dated 07/09/2022, revealed the resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14. During an observation and interview on 09/12/2022 at 2:25 PM, Resident #74 sat in a motorized wheelchair at the front of the building smoking a cigarette. The resident sat by a bench. Resident #74 stated he/she usually smoked in front of the building and noted that, when done with a cigarette, he/she threw the cigarette butt in a nearby trash can since there was nowhere else to put them out. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation on 09/12/2022 at 2:35 PM revealed the trash can where Resident #74 was observed smoking ten minutes prior contained cigarette ashes on top of the trash can. The trash can was lined with a plastic bag and had combustible materials, namely paper bags, inside of the receptacle. During an observation and interview on 09/12/2022 at 3:10 PM, Resident #74 was lying in bed and stated he/she could smoke when desired and had been instructed by the facility to smoke out back in a facility-designated smoking area or off the property. The resident stated he/she sometimes went off the property to smoke. Resident #74 reported he/she always maintained possession of his/her cigarettes and lighter. The resident confirmed the facility instructed him/her not to smoke at the front of the building. During an interview on 09/12/2022 at 3:15 PM, Certified Nursing Aide (CNA) #3 confirmed Resident #74 smoked and had been told to smoke outside in the designated smoking area, which she noted had a smoking sign designating it as such. She identified she had observed the resident smoking outside at the front of the facility, which she noted was not a designated smoking area. CNA #3 reported she was unaware the front of the building lacked a smoking receptacle since it was not a designated smoking area. During an interview on 09/12/2022 at 3:21 PM, Licensed Practical Nurse (LPN) #4 confirmed Resident #74 smoke [TRUNCATED]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28196 Based on observations, record review, interviews, and facility policy review, the facility failed to store, distribute, and serve food in accordance with professional standards of food service safety in 1 of 1 kitchen. Specifically, the facility: - Failed to ensure food items in the walk-in cooler and freezer were properly sealed, labeled, and dated when opened. - Failed to ensure food items that were visibly spoiled were removed from stock / discarded. - Failed to ensure a refrigerator on Arbor Unit, where residents' food was stored, was maintained in proper working order. - Failed to ensure an ice chest used to pass ice/water to residents on Arbor Unit was cleaned/sanitized after becoming contaminated. - Failed to ensure food delivered from the kitchen was covered during transport to a resident. These failed practices had the potential to affect 174 residents who received food from the kitchen, including 11 residents who also received food from the refrigerator and ice chest on Arbor Unit. Findings included: 1. Review of a facility policy titled, Food Storage: Dry Goods, revised 09/2017, revealed, All dry goods will be appropriately stored in accordance with the FDA [Food and Drug Administration] Food Code. The policy also indicated, All packaged and canned food items will be kept clean, dry, and properly sealed. Additionally, the policy indicated, Storage areas will be neat, arranged for easy identification, and date marked as appropriate. Review of a facility policy titled Food Storage: Cold Foods, revised 04/2018, revealed All Time / Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. The policy further indicated, All perishable foods will be maintained at a temperature of 41 degrees F [Fahrenheit] or below, except during necessary periods of preparation and service. Additionally, the policy indicated, All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. 1.a) On 09/12/2022 at 8:54 AM, during an initial tour of the kitchen with the Assistant Dietary Manager (DM), the following observations/interviews were conducted: - The walk-in freezer contained a bag of meatballs dated 08/31/2022 that was opened and not sealed, and a tray of cobbler dated 08/31/2022 with the corner not sealed and opened to air. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- In the walk-in cooler, there was a metal container of biscuits and bread not sealed, with loose plastic wrap that was opened to air; and a container of strawberries with a white, furry substance on two of the berries. The Assistant DM stated the container of strawberries should have been thrown away and removed them from the shelf. - In the dry storage area, there was an opened box of lemonade drink mix with three packages in the box not dated. The Assistant DM stated the items in the walk-in cooler, freezer, and dry storage area should have been sealed, labeled, and dated when opened. During an interview on 09/15/2022 at 1:00 PM, the Regional Dietary Manager (RDM) stated she expected all food to be dated and labeled when received and opened and all food to be properly bagged and sealed to prevent exposure to air and the possibility for decreased food quality. She also indicated any spoiled food should be immediately removed to prevent cross contamination and the possibility of foodborne illness. During an interview on 09/15/2022 at 5:05 PM, the Administrator stated he expected dietary staff to make sure all foods were bagged, sealed, and dated when opened, per regulations, and to immediately pull any foods from stock upon first noticing spoilage. 1.b) During an observation on 09/13/2022 at 9:24 AM, a double-sided refrigerator on the Arbor Hall had signs posted instructing that the refrigerator not be used due to it being shut down until further notice. The following items were stored in the refrigerator: - an approximately one-fourth full pitcher of cranberry juice, dated 9/8 - 9/15 (09/08/2022 to 09/15/2022); - an opened jar of Miracle Whip, not dated; - a full pitcher of fortified milk, dated 9/6 - 9/9 (09/06/2022 to 09/09/2022); - a full pitcher of chocolate milk, dated 9/6 - 9/9; - two unopened cartons of Silk milk with a use-by date of 09/25/2022; - a snack-size box of fried chicken from a fast-food restaurant, not labeled or dated; and, - a covered fruit plate, dated 9/12 - 9/18 (09/12/2022 to 09/18/2022). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 09/13/2022 at 9:33 AM, the Assistant Dietary Manager (DM) stated she was aware of the signs on the refrigerator and revealed the signs were posted because the refrigerator temperature stayed around 50 degrees Fahrenheit (F.) and that this was not a safe temperature at which to store food. She reported that her supervisor and the Administrator were aware of the malfunctioning refrigerator and were aware that staff (not dietary staff) continued to put food and beverages in the refrigerator. She also reported she had emptied the refrigerator multiple times, and she was not aware that anyone had placed additional items in the refrigerator since she emptied it sometime last week. She checked the temperature in the refrigerator at this time and reported it was 48 degrees F. She stated if staff, residents, or visitors gave the residents anything out of the refrigerator, the residents could get sick. She stated she would not recommend anyone eating the chicken or the milk products, noting that consuming either of those items could make them very sick. During an interview on 09/15/2022 at 5:05 PM, the Administrator stated he was just made aware today that staff continued putting food and beverages in the refrigerator on Arbor Hall after signs were posted instructing them not to use the refrigerator. He stated he expected that no one store food in that refrigerator until it was fixed, since it was not holding an acceptable temperature. He indicated this could cause food spoilage and could result in foodborne illnesses if the food was ingested. 40141 2. Review of a facility policy titled, Meal Distribution, last revised 09/2017, revealed, All foods that are transported to dining areas that are not adjacent to the kitchen will be covered. Review of an Admission Record revealed Resident #52 had diagnoses of end stage renal disease and type 2 diabetes mellitus. A review of an admission Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. The resident was independent with eating and required supervision of one person with personal hygiene. 2.a) During an observation on 09/14/2022 at 1:28 PM, Resident #52's meal tray was delivered by an unidentified Certified Nursing Assistant (CNA). The resident commented on one of the items on the tray, and the CNA offered the resident an alternate, then left the unit to obtain it. During an observation and interview on 09/14/2022 at 1:46 PM, CNA #1 entered the unit with a sandwich on a plate for Resident #52. The sandwich was not covered. CNA #1 indicated the kitchen sent the sandwich uncovered. CNA #1 placed the uncovered sandwich in the resident's room and left. During an observation on 09/14/2022 at 2:32 PM, the uncovered sandwich remained in Resident #52's room. Licensed Practical Nurse (LPN) #3 was informed about the uncovered sandwich. During an observation on 09/14/2022 at 2:35 PM, a staff member removed the uncovered sandwich from Resident #52's room. During an interview on 09/15/2022 at 12:54 PM, CNA #2 indicated food or drink should be covered with a lid or plastic wrap when transported from the kitchen. CNA #2 indicated uncovered food that had been transported from the kitchen should not be left in a resident's room. (continued on next page)

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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	During an interview on 09/15/2022 at 2:02 PM, CNA #1 indicated food was supposed to be covered when it left the kitchen. CNA #1 stated the sandwich did not have a cover but should have. CNA #1 acknowledged the sandwich would have been contaminated and should not have been left in the resident's room. During an interview on 09/15/2022 at 2:41 PM, the Registered Nurse-Infection Preventionist (RN-IP) indicated food should be covered when transported from the kitchen. The RN-IP stated the uncovered sandwich should not have been left in Resident #52's room and indicated this was cross-contamination. During an interview on 09/15/2022 at 3:19 PM, the Registered Dietitian indicated the kitchen staff were to obtain the requested food, put it on a plate, and then cover it before giving it to the CNA. The Registered Dietitian indicated food should never leave the kitchen uncovered. During an interview on 09/15/2022 at 5:03 PM, the Registered Nurse Consultant (RNC) indicated the uncovered sandwich should not have been left in the resident's room. The RNC indicated her expectation was for food to be covered and beverages to have a lid or be covered when being transported from the kitchen. During an interview on 09/16/2022 at 8:28 AM, the Administrator indicated his expectation was that staff transport food covered from the kitchen. 2.b) During an observation on 09/14/2022 at 1:54 PM, Resident #52 was at the ice chest with the ice scoop in his/her hand and stated the CNAs were busy. Resident #52 placed the scoop back in the scoop holder and did not obtain ice. The resident was holding a wrapped sandwich and indicated he/she had remembered ordering two gyros yesterday evening, and that they were in the drawer in his/her room. Resident #52 indicated the wrapped sandwich was cool and held it out for the surveyor to feel. The sandwich was not cool to touch, and the resident was asked if he/she thought it should be eaten. The resident stated, Yeah, it will be okay. At this time, CNA #1 returned to the area, took the sandwich without asking any questions and stated, We have a microwave. CNA #1 to the sandwich to the microwave, then returned with the sandwich, and gave it to the resident. She then went over to the ice chest and obtained ice for the resident. While CNA #1 obtained the ice, the surveyor informed her about the resident holding the ice scoop and putting it back in the scoop holder. CNA #1 placed the ice scoop back in the holder without cleaning it and left. The ice chest remained in the dining room. During an observation on 09/14/2022 at 2:14 PM, the surveyor stopped a therapist from using the ice scoop. Licensed Practical Nurse (LPN) #2 was approaching in the hallway and was told about the ice scoop. LPN confirmed the scoop was contaminated. Resident #52 stated the CNA had wiped the handle of the scoop. The surveyor informed LPN #2 that the CNA had not wiped the scoop handle. LPN #2 was asked if the surveyor could speak with CNA #1. LPN #2 left the area, leaving the ice chest and holder. LPN #3 and another nurse arrived and were informed of the contaminated ice scoop and the leftover gyro. LPN #3 indicated the ice was contaminated then left with the other nurse to obtain CNA #1. The ice chest remained in the dining room. During an observation and interview on 09/14/2022 at 2:23 PM, CNA #1 returned to the ice chest and stated, I'm going to go clean this. CNA #1 indicated the ice scoop was contaminated. CNA #1 denied cleaning the ice scoop handle before she had used, it then removed the ice chest from the area. (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	09/16/2022

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/14/2022 at 2:32 PM, LPN #3 denied having seen the leftover gyro in the resident's room earlier when he had checked. During an interview on 09/15/2022 at 12:54 PM, CNA #2 indicated that Resident #52 did store food in his/her room, and staff would sometimes place it in the refrigerator with the resident's name and date on it. CNA #2 indicated she would ask the resident where the food came from and when. CNA #2 indicated residents were not allowed to obtain their own ice. CNA #2 indicated the scoop would have been contaminated if a resident had handled it. CNA #2 indicated that would be an infection control issue and stated the scoop should have been removed and cleaned after staff were aware it had been handled by a resident. During an interview on 09/15/2022 at 2:02 PM, CNA #1 indicated the resident did go and get his/her own food sometimes but acknowledged she should have asked where the food came from. CNA #1 indicated staff provided residents with ice due to concerns of cross-contamination. CNA #1 indicated the scoop would be contaminated if the resident handled it. CNA #1 indicated she should have removed the ice chest and disinfected it when she was told the resident had handled the scoop. During an interview on 09/15/2022 at 2:41 PM, the Registered Nurse-Infection Preventionist (RN-IP) stated the CNA should have inquired about where the gyro had come from, and it should not have been heated and served without knowing where it had been stored or for how long. The RN-IP indicated residents were not allowed to serve their own ice. The RN-IP stated the CNA should not have left the ice scoop and chest for further use after the scoop was handled by the resident and then used by the CNA. During an interview on 09/15/2022 at 5:03 PM, the Registered Nurse Consultant (RNC) indicated residents were not allowed to obtain their own ice. The RNC indicated her expectation was for residents to allow staff to get the ice to ensure infection control processes were maintained. During an interview on 09/16/2022 at 8:28 AM, the Administrator indicated ideally, the resident should not have had food in his/her drawer, but he did not expect staff to check residents' drawers for this. The Administrator indicated his expectation was for staff to offer residents something else if food had been stored in the resident's room. The Administrator indicated residents were not allowed to obtain their own ice. The Administrator indicated that after the CNA was informed about the resident touching the ice scoop, the CNA should have disinfected the scoop and the holder. The Administrator indicated his expectation was for residents to not use the ice chest or use ice scoops. During an interview on 09/16/2022 at 8:56 AM, the RNC indicated the ice chest that the resident had attempted to use only served one part of the Arbor Hall unit. The RNC indicated that ice chest was not used for the quarantine hall.