STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065108	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villas at Sunny Acres, The	2501 E 104th Ave Thornton, CO 80233

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to inform the resident's representative of the change in condition for one (#176) out of five residents reviewed out of 49 sample residents. Specifically, the facility failed to timely notify Resident #176's representative of a fall, the need for medical imaging (Xray) of her left hip, new orders for pain medication and an appointment for a diagnostic imaging procedure to show detailed internal images (CT) scan in a timely manner. Findings include: I. Facility policy and procedure The Change of Condition Reporting policy, revised October 2020, was provided by the nursing home administrator (NHA) on 4/3/25 at 10:30 a.m. The policy read in pertinent part, The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken. All attempts to reach the physician and responsible party will be documented in the nursing progress notes. Documentation will include time and response. II. Resident #176 A. Resident's status Resident #176, age [AGE], was admitted to the facility on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included heart rhythm disorder (A-Fib), heart failure, history of transient ischemic attack (TIA) and cognitive communication deficit. The 1/23/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 10 out of 15. B. Representative interviews Resident #176's daughter-in-law was interviewed on 4/3/25 at 3:43 p.m. She said the resident's representative (Resident #176's son) was at the facility the morning of 2/11/25 to discuss discharging Resident #176 to the resident's home. The resident's representative was told by an unidentified case manager the resident had more insurance days and the team would discuss the discharge and call him back. The resident's representative spoke to a case manager later in the day and was only then notified there had been a change of condition due to a fall the night before (2/10/25) and the resident's (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition had deteriorated. Resident #176's daughter-in-law said during the next several days they saw Resident #176 getting weaker and lying in bed. The daughter-in-law said the resident was not acting like herself because of the pain medication. Resident #176's daughter-in-law said prior to 2/10/25 there was a meeting with the family, resident, staff members including the case manager to discuss the passing of Resident #176's daughter and now the primary contact would be the resident's representative, her son. Resident #176's representative was interviewed on 4/3/25 at 5:11 p.m. He said he visited Resident #176 the morning of 2/11/25 and spoke to an unidentified case manager about discharging Resident #176 to her home that day. Resident #176's representative was told she still had insurance coverage and the team would discuss the discharge and call him back. He said there was no communication about the fall while he was there in the morning, He said Resident #176 was complaining of pain the morning of 2/11/25, which was new for her. He said he talked to a case manager later in the afternoon and was advised, because of Resident #176's change of condition, discharge was not recommended. He said he was then notified of the 2/10/25 fall and of the Xrays that were taken on 2/11/25. He said he had no prior notification from the facility regarding the fall or Xrays. He said he was told that the facility tried to call Resident's #176's daughter. He said the facility was aware that she passed away. He said there was a meeting for Resident #176 which included the case manager regarding the passing of the resident's daughter. He said he was listed as the first contact. He said he noticed a change in the resident and she was sleeping more, not getting out of bed and was told she was on pain medications after the medication was started. Resident #176's representative said he was not notified of the 2/20/25 CT scan appointment until the morning of 2/20/25 when he went to visit his mother and she was not at the facility. Resident #176's representative was then advised of the appointment. He said had been visiting sometimes up to three times a day prior to her rehospitalization. C. Record Review The nursing facility's face sheet listed Resident #176's representative, her son, as first emergency contact. There was no one listed as the resident's power of attorney (POA). There was only one contact listed. A progress note, dated 2/10/25 at 10:45 p.m., documented in pertinent part, the family member or representative was notified on 2/11/25 at 6:00 a.m. -The note did not specify which family member/representative was notified. A progress note, dated 2/10/25 at 11:03 p.m., documented in pertinent part, the nurse practitioner (NP), on-call nurse and POA were notified of the resident's fall. A progress note, dated 2/11/25 at 5:48 a.m., documented the writer attempted to call Resident #176's daughter and POA twice to notify her of the resident's fall. The phone went immediately to voicemail and the writer was unable to leave a message due to the mailbox being full. This was passed on to the dayshift nurse to try and contact the daughter again. -However, the facility was notified Resident #176's daughter passed away prior to 2/10/25, see interviews above. Resident's #176 daughter was not listed on the face sheet. A progress note, dated 2/11/25 at 12:26 p.m., documented an Xray of the left hip was completed due to a fall and were negative for a fracture. The Xray results were received and communicated to the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician. Review of the February 2025 CPO revealed the following physician's orders: Tramadol 50 milligram (mg) one tablet by mouth every six hours as needed for moderate and severe pain, ordered 2/11/25; and, Tylenol 1000 mg by mouth every eight hours as needed for pain, ordered 2/11/25. -Review of Resident #176's electronic medical record (EMR) failed to show the resident's representative (Resident #176's son) was notified of the 2/10/25 fall, the ordered Xrays or the addition of pain medication at the time when it occurred. D. Staff interviews The director of nursing (DON) and the regional clinical resource (RCR) were interviewed together on 4/2/25 at 5:15 p.m. The DON said the expectation was for the responsible party to be notified after a fall. Primary care physician (PCP) #1 was interviewed 4/3/25 at 2:50 p.m. PCP #1 said she had no contact with the family regarding the resident's fall or plan of care. PCP #1 said she asked the resident if she wanted to go to the hospital for tests or stay at the facility for Xrays. PCP #1 said the resident chose to stay at the facility. She said it was the facility's responsibility to contact the responsible party after a fall. III. Facility follow-up The NHA provided additional information on 4/4/25 at 12:43 p.m., after the exit. The NHA sent a screen shot of a phone and said it belonged to social worker's (SW) #1's phone. The screen shot revealed SW #1 called the resident's representative (son) phone on 2/11/25 at 2:43 p.m., lasting 34 seconds. Another screen shot revealed an incoming call from the resident's representative's phone number on 2/11/25 at 3:09 p.m. The NHA said SW #1 provided notification of the fall and Xray results at that time. -However, Resident #176 fell on 2/10/25 at approximately 10:15 p.m. and the resident's representative was not notified until 2/11/25 at 3:09 p.m., approximately 17 hours after the fall occurred, after Xrays were taken and medications were ordered. The NHA provided a written statement from SW #1 on 4/4/25 at 12:43 p.m. The 4/4/25 statement read in pertinent part, SW #1 notified the resident's representative of the fall and Xray results during the phone conversation on 2/11/25 at 3:09 p.m.