STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065193	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thornton Care Center	501 Thornton Pkwy Thornton, CO 80229

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure three (#10, #11 and #14) of 14 residents reviewed for grievances were provided prompt efforts by the facility to resolve a grievance out of 14 sample residents.Specifically, the facility failed to respond to grievances from Resident #10, Resident #11 and Resident #14 when they reported to facility staff that room temperatures were uncomfortable and hot.Findings include:I. Facility policy and procedureThe Resident Rights policy, revised February 2021, was provided by the nursing home administrator (NHA) on 8/18/25 at 1:45p.m. It read in pertinent part, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the right to voice grievances and have the facility respond to the grievances.II. ObservationsOn 8/19/25 at 12:45 the following temperatures were taken throughout the facility:On the west unit: -room [ROOM NUMBER], was 81.1 degrees Fahrenheit (F).-room [ROOM NUMBER] was 83.7 degrees F.-The hallway common area was 84.4 degrees F.-The hallway was 82.2 degrees F.-room [ROOM NUMBER] was 88.9 degrees F.The main entryway was 81.7 degrees F.The [NAME] unit had two water coolers in the hallway. One water cooler was off and the water cooler at the end of the hallway was blowing warm air. Five residents sat in wheelchairs in the common area, where the room temperature was 84.4 degrees F.On the east unit:-room [ROOM NUMBER] was 87.4 degrees F. III. Resident interviewsResident #11 and his representative were interviewed together on 8/19/25 at 12:55 p.m. Resident #11 said his room was uncomfortably warm, even with a floor fan. He said the floor fan did not help to keep his room cool and he had to sit directly in front of it to stay cool. The resident's representative said the room felt too warm. Resident #11 said he had complained about hot room temperatures to staff and said he felt that staff did not care. Resident #14 was interviewed on 8/19/25 at 5:10 p.m. Resident #14 said his room and hallways were very warm during the summer days. Resident #14 said his room could not be cooled because the air coolers were located at opposite ends of the hallway and the cool air did not effectively reach his room. He said he had a fan in his room, but it was small and only moved the hot air around his room.Resident #10 was interviewed on 8/20/25 at 9:45 a.m. Resident #10 said her room was hot and the thermometer hanging on her inside wall frequently registered temperatures in the upper 80's and up to 94 degrees F. Resident #10 said she had reported her concerns about room temperatures to facility staff and management several times and the room temperature had remained uncomfortable and hot. She said her room was located at the end of a hallway and far away from the water coolers.IV. Record reviewA request for grievances regarding the temperature of the residents' rooms and the common area was made on 8/19/25 at 1:09 p.m. The NHA said there were no documented grievances regarding the temperatures of the facility. -However, Resident #10 said she had reported her concerns to the staff regarding the temperatures of her room (see interview above).V. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 8/19/25 at 1:10 p.m. LPN #1 said the room temperatures (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the facility's hallways were always high. She said she was unsure when the water cooler was turned off and said only maintenance personnel were authorized to adjust the cooling fans. LPN #1 said on hot days, residents were provided with extra ice. Certified nurse aide (CNA) #1 was interviewed on 8/19/25 at 1:05 p.m. CNA #1 said the facility hallways were hot and he said the cooler fan was off because a resident complained it was cold in the hallway. The NHA was interviewed on 8/19/25 at 1:15 P.M. The NHA said he was unaware of acceptable room temperatures and said he had no current complaints from residents about room temperatures.The NHA was interviewed again on 8/19/25 at 2:40 p.m. The NHA said the maintenance director (MTD) was aware the cooling fan was not working in the morning (on 8/19/25) on the [NAME] unit and replaced a fan motor. The NHA said the cooling fan was now operational and the MTD had verified that all the facility's water coolers were operational. The NHA said on hot days, the facility provided extra ice and popsicles to the residents, closed dark shades, checked on residents frequently and offered outdoor activities. The NHA was interviewed a third time on 8/20/25 at 9:40 a.m. The NHA said the facility had rented two large water coolers for the [NAME] and East units because the residents' room temperatures remained high on 8/19/25. The MTD was interviewed on 8/20/25 at 2:25 p.m. The MTD said the facility was an old building and the water coolers were old and inefficient. The MTD said the two rented water coolers were effective to cool the facility hallways and residents' room temperatures to safe temperatures.

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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 - 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 observations, record review and interviews, the facility failed to ensure two (#1 and #4) of five residents reviewed for accident hazards received adequate supervision out of 14 sample residents.Resident #1 was admitted to the facility with diagnoses of neurocognitive disorder, brain injury with loss of consciousness and arthritis. According to documentation, Resident #1 had four falls from 6/6/25 to 7/9/25. Two falls required evaluation and treatment at the hospital emergency department. The fall on 6/21/25 caused a pelvic fracture, and after a fall on 7/9/25, the resident was monitored and was allowed to go on an activity trip to a local restaurant for lunch on the same day. While at the restaurant, the resident had another fall on 7/9/25 and was transferred to the emergency department. The hospital physician determined Resident #1 had fainted due to dehydration. On 6/8/25 at 11:00 a.m., a staff member found Resident #1 on the floor in the main entrance common area. A nurse assessed Resident #1 and determined Resident #1 was not injured from the fall. The risk management fall review note was reviewed and documented the root cause of the fall was from an unsteady balance. Resident #1's fall prevention care plan interventions were updated 6/18/25 (10 days later) and included calling staff for assistance when she felt weak or dizzy. On 6/21/25 at 11:21 a.m., staff found Resident #1 on the floor in the main entrance common area. A nurse assessed the resident and notified the provider that Resident #1 complained of head and neck pain. Resident #1 was transferred to the emergency room and was diagnosed with a pelvic fracture. The 6/21/25 risk management fall review note was reviewed and revealed the root cause of the fall was due to a personal history of traumatic brain injury with a loss of consciousness. There were no changes made to Resident #1's fall prevention care plan after the fall.On 7/9/25 at 5:25 a.m., Resident #1 fell and was found by staff in a non-verbal condition. A nurse assessed Resident #1 and documented Resident #1 was verbally responsive after a few minutes. There was no documentation of ongoing nursing assessments after the fall, and there were no immediate changes to the resident's fall prevention care plan.On 7/9/25 at 11:01 a.m., Resident #1 traveled on a facility sponsored outing to a restaurant. While at the restaurant, Resident #1 was found on the floor in the bathroom and was transferred to the emergency department. The resident had not been assisted by staff to use the restroom during the outing. The resident was diagnosed with syncope (fainting) from dehydration. The 7/16/25 risk management fall review note documented Resident #1 fell twice on 7/9/25 due to poor safety awareness and having an unsteady gait. The 7/23/25 interdisciplinary team (IDT) progress note documented a physical therapy evaluation was initiated for Resident #1, which was 14 days after the fall.Additionally, Resident #4, who was assessed to have Alzheimer's disease, history of a stroke, right sided paralysis, history of falling, sepsis and cognitive communication deficits was transported by her spouse to an optometry appointment on 8/4/25. While at the appointment, Resident #4 fell from her motorized scooter and sustained a head laceration and thoracic spine fracture. Upon initial facility admission, the facility assessed Resident #4 to be independent while operating a manual wheelchair. However, the resident had a power-wheelchair. There was no documentation the facility completed an assessment to determine if Resident #4 had the cognitive or physical ability to operate a power-mobility equipment/wheelchair/scooter safely. There was no documentation the IDT reviewed or revised Resident #4's care plan after the 8/4/25 fall. Specifically, the facility failed to: -Ensure Resident #1, who was assessed to have a fall history, a history of brain injury, moderate cognitive impairment, memory impairment and required teaching in segments, remained free of falls with injury; and,-Ensure Resident #4, who had fractured joints upon arrival to the facility was assessed for an ongoing ability to safely operate her power-mobility (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	equipment/scooter to prevent Resident #4 from falling from the scooter while at an appointment.Findings include:I. Facility policy and procedureThe Fall Management policy, dated 2/29/24, was provided by the nursing home administrator (NHA) 8/20/25 at 2:20 p.m. It revealed in pertinent part, The purpose of this fall management policy is to modify or eliminate risk factors and thereby attempt to reduce the likelihood of falls with significant injury. A fall reduction program will be established and maintained to assess all residents to determine their risk for falls. A plan will be implemented based on the resident's assessed needs.To be effective a fall reduction program will include a fall risk evaluation, care planning and implementation of interventions, and ongoing evaluation of the process. A fall risk evaluation will be completed within 24 hours of admission and a baseline care plan will be initiated for residents determined to be at risk for falls. Individualized care plan interventions will be implemented for those residents found to be at high risk for falls. Interventions are to be re-evaluated when a resident falls for efficacy. Educate and communicate implemented interventions to direct care staff via verbal report. Document the residents' response to fall prevention interventions and revise interventions if the interventions are not successful. If a resident experiences an unwitnessed fall, neurological checks will be initiated. The facility will review all falls daily during the morning quality meeting. The fall review will include review of the incident report, review that a care plan was initiated, revise the plan of care after a fall as necessary.II. Resident # 1A. Resident statusResident #1, age greater than 65, was admitted on [DATE], discharged to the hospital on 7/9/25 and was readmitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included neurocognitive condition without behavioral disturbance, unspecified intracranial injury with loss of consciousness, insomnia, osteoarthritis and history of falling.The 4/24/25 minimum data sets (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident was independent from staff assistance for bed mobility, sitting and standing, transferring and walking with a walker. B. Resident interview and observationResident #1 was interviewed on 8/20/25 at 12:10 p.m. Resident #1 said she was happy at the facility. Resident #1 said she enjoyed walking to activities, to visit with her friends and to the dining room for meals. Resident #1 said if she needed help in the common areas she was not sure what she should do and said she would sit and rest on a chair. Resident #1 said she did not need very much assistance and said she was unsure when she should request assistance from staff. Resident #1 said staff gave her several instructions that were confusing. Resident #1 was observed ambulating independently on 8/18/25, 8/19/25 and 8/20/25 throughout the facility using a front-wheeled walker. Resident #1 ambulated slowly with short jerking steps and had a limp on her right side. Resident #1 was observed sitting at a table by herself in the common area, near the main entrance, where she made flower arrangements. The common area did not have access to a call light to use if a resident needed assistance, and the resident was not provided with a way to notify staff if she needed help. C. Record reviewResident #1's fall care plan, initiated 4/18/25, revealed Resident #1 was at risk for falls related to a neurocognitive disorder, intracranial injury with loss of consciousness, impaired balance, poor safety awareness, history of falls and osteoarthritis in her right knee. Interventions included ensuring Resident #1 wore appropriate footwear when ambulating (initiated 4/18/25), ensuring Resident #1 had her call light in reach, encouraging Resident #1 to use her call light, responding promptly to requests for assistance, encouraging Resident #1 to participate in activities to promote exercise for strengthening (initiated 4/23/25), calling for assistance with feeling weak and dizzy (initiated 6/18/25), assessing and meeting Resident #1's needs, providing adaptive devices as needed, educating Resident #1 about safety reminders and what to do when (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a fall occurs, encouraging rest periods when signs of fatigue are noted, requesting a medication review with the pharmacist (initiated 7/18/25), using a wheelchair on all outings for fall prevention, and a physical therapy evaluation (initiated 7/23/25).Resident #1's functional performance care plan, initiated 4/18/25, revealed Resident #1 had a self-care deficit related to epilepsy, neurocognitive disorder, intracranial injury with loss of consciousness, impaired balance, poor safety awareness, history of falls and osteoarthritis in her right knee. Interventions included using the call bell to call for assistance (initiated 4/18/25), transferring independently between surfaces (initiated 4/23/25) and using a walker for ambulation (initiated 5/1/25).Resident #1's cognitive care plan, initiated 4/23/25, revealed Resident #1 had impaired cognition or thought processes related to cognitive disorder, history of traumatic brain injury and moderate cognitive impairment. Interventions included using task segmentation to support short term memory deficits and breaking tasks into one step at a time.-Resident #1 had a fall prevention care plan that identified Resident #1 was assessed to have moderate cognitive impairment. The resident was not assessed to determine if she understood the fall prevention and safety awareness interventions included on the care plan. Resident #1 walked independently throughout the facility with her walker and there were no assessments to indicate that Resident #1 had the cognitive ability to locate and activate a call light to request assistance from her room or common areas when she felt weak or dizzy.D. Falls1. Fall #1 The 6/11/25 nurse progress note, documented on 6/8/25 at 11:00 a.m., revealed Resident #1 was found on the floor, in the common area of the main entrance, sitting on her buttocks. The nurse completed an assessment and found no injuries. The nurse documented Resident #1 said she felt unsteady on her feet and sat down on the floor. The 6/16/25 IDT progress note revealed the IDT determined the cause of the fall was due to Resident #1's clinical diagnoses. The IDT recommended a new intervention for Resident #1 to call for assistance when she felt weak or dizzy. -However, the IDT made no referrals to the therapy department for evaluation of Resident #1's unsteadiness and weakness in an attempt to prevent future falls.2. Fall #2 The 6/21/25 at 12:36 p.m. nurse progress note, documented on 6/21/25 at 11:21 a.m., revealed that Resident #1 was found on the floor, in the common area of the main entrance. The nurse completed a physical assessment and documented Resident #1 was non-verbal. The nurse documented neurological assessments were initiated, however, the facility was unable to provide the documentation of the neurological assessments. The progress note documented that Resident #1 complained of head and neck pain, and was transported to the emergency department for evaluation. The 6/21/25 hospital discharge summary revealed Resident #1 was diagnosed with a hip bruise, a pelvic fracture and sacroiliac (pelvis) joint dysfunction.General discharge instructions included: -Rest as needed, return to your normal activities as told by your health care provider, ask your health care provider what activities are safe for you;-Do exercises as told by your health care provider or physical therapist;-Keep all follow-up visits; and,-Call 911 if you have increased pelvic swelling, pain or redness of a leg or chest pain. -The 6/24/25 IDT progress note revealed there were no new care plan interventions initiated to include the discharge instructions and there were no changes made to Resident #1's fall prevention care plan. 3. Fall #3The 7/9/25 at 6:00 a.m. nurse progress note documented Resident #1 was found on the floor in the hallway outside the nurses' station. The nurse documented Resident #1 denied pain during assessment, was assisted to her feet and went to the common area by the main entrance. -The nurse documented neurological assessments were started; however, there were no neurological assessments in the resident's electronic medical record (EMR) for the fall. -Further, there was no documentation to indicate that Resident #1 had ongoing monitoring after the fall, which might reveal changes to vital signs or a change in condition.The 7/9/25 5:25 a.m. fall investigation revealed Resident #1 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	had a predisposing physiological factor of a walking imbalance, had her walker with her and was carrying several personal belongings. There were no changes made to the resident's plan of care after the fall.4. Fall #4The 7/9/25 11:01 a.m. fall investigation revealed Resident #1 fell at a local restaurant while she was on an outing with the facility's activities department. The progress note revealed emergency services were contacted while at the restaurant. Resident #1 was evaluated at the hospital and was diagnosed with recurrent syncope with falls from dehydration. The 7/9/25 fall investigation revealed Resident #1 had predisposing factors of gait imbalance and a recent change in cognition. The 7/10/25 hospital discharge summary revealed Resident #1 told the hospital physician the syncope episodes happened upon standing up after being seated. Review of Resident #1's EMR revealed the facility failed to provide the resident with increased supervision for timely intervention from staff to prevent falls upon standing. The 7/16/25 at 7:58 p.m. IDT progress note revealed the IDT determined the cause of the 7/9/25 falls were poor safety awareness and an unsteady gait. The 7/23/25 IDT note documented Resident #1 was educated to use a wheelchair on future outings to prevent falls due to the unsteady gait and disease processes. The progress note further documented the IDT initiated a referral for physical therapy, which was 14 days after the falls on 7/9/25.III. Resident #4A. Resident statusResident #4, age greater than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included Alzheimer's disease, stroke, right side paralysis, history of falling, sepsis and cognitive communication deficit.The 8/2/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. Resident #4 was independent from staff assistance for bed mobility and sitting up in bed, and required set-up assistance from staff for sitting and standing, and transferring from a chair to a bed. Resident #4 was independent from staff assistance for mobility using a manually propelled wheelchair. Resident #4's ability for car transfers was not assessed. B. Record reviewResident #4's fall care plan, initiated 6/22/25, revealed Resident #4 was at risk for falls related to encephalopathy (a group of conditions that cause brain dysfunction), type 2 diabetes mellitus, Alzheimer's disease and a history of falling at home. Interventions included ensuring Resident #4 had a call light in reach and encouraging Resident #4 to use the call light for assistance as needed and responding promptly to all requests for assistance (initiated 6/22/25), encouraging Resident #4 to participate in activities to promote exercise for strengthening (initiated 6/22/25), ensuring adequate lighting and visual aids were in place (initiated 6/22/25), ensuring Resident #4 wore appropriate footwear when mobilizing in a wheelchair (initiated 6/22/25) and physical therapy as ordered (initiated 6/22/25). Resident #4's impaired cognitive function care plan, initiated 8/8/25, revealed Resident #4 had impaired thought processes related to Alzheimer's disease. Interventions included discussing concerns about confusion, disease processes and facility placement with Resident #4 (initiated 8/8/25) and monitoring for changes in cognitive function (initiated 8/8/25). Resident #4's functional mobility care plan, initiated 6/22/25, revealed Resident #4 had a self-care deficit related to Alzheimer's disease, encephalopathy and limited mobility. Interventions included using a power wheelchair for mobility throughout the facility (initiated 6/22/25) and encouraging Resident #4 to use the call bell to call for assistance (initiated 6/22/25).The 8/4/25 at 3:04 p.m. nurse progress note documented Resident #4 was out of the facility with her spouse for an optometry appointment. While at the appointment, Resident #4 fell from her wheelchair and was transported to the emergency department for evaluation. The 8/4/25 at 3:01 p.m. hospital summary documented Resident #4 was evaluated in the emergency department. The emergency department physician ordered computed tomography (CT) scans for Resident #4. The 8/4/25 CT scan revealed Resident #4 sustained a thoracic spine compression fracture. The treatment recommendation was for Resident #4 to wear a thoracic (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	brace and return to the facility. The 8/4/25 at 6:47 p.m. nurse progress note documented the social services director (SSD) asked the nurse to obtain a pass for Resident #4 to attend an optometry appointment. The progress note documented that Resident #4 left the facility, accompanied by her spouse. The spouse returned to the facility later and informed the nurse that Resident #4 was left unattended while he parked his vehicle, and while unattended, Resident #4 fell to the ground. The spouse told the nurse Resident #4 had an open area on her head and was transported by paramedics to the hospital. On 8/5/25, the IDT outing evaluation for a pass was completed. The IDT determined Resident #4 had poor safety awareness and recommended Resident #4 not leave the facility independently, but she could have a therapeutic pass when accompanied by an adult. -There was no documentation to indicate the facility provided education to the resident's spouse for safe car transfers and to not leave Resident #4 unattended while on outings. Review of Resident #4's EMR revealed there was no documentation to indicate the IDT reviewed the fall or updated Resident #4's plan of care for fracture care or completed a wheelchair/scooter use and safety evaluation at the time of admission or after the fall on 8/4/25.IV. Staff interviewsRegistered nurse (RN) #1 was interviewed on 8/19/25 at 12:55 p.m. RN #1 said that he was aware Resident #1 had a history of falls and said Resident #1 was independent with walking around the facility. RN #1 said Resident #1 participated in therapy and appeared to be stronger when she walked with her walker. RN #1 said staff monitored Resident #1 frequently and provided assistance as needed. RN #1 said he was unsure why Resident #1 had repeated falls.Licensed practical nurse (LPN) #1 was interviewed on 8/19/25 at 1:10 p.m. He said Resident #4 used a wheelchair and had a brace for her spine fracture. LPN #1 said Resident #4 required narcotic pain medication for pain in her spine. LPN #1 said nurses kept up-to-date report sheets with important notes for each resident. LPN #1 said that after a resident had a fall, the status of each fall and monitoring should be included in the shift report. LPN #1 said that if documentation in the EMR was not immediate, the shift report was the only way for nurses to track resident status. LPN #1 said it was important for staff to know why residents fell so that staff could monitor the residents and provide safe care.The activities director (AD) was interviewed on 8/20/25 at approximately 2:45 p.m. The AD said that on 7/9/25, he took residents on a scheduled activity/outing to a local restaurant. The AD said Resident #1 fell while inside the restaurant and paramedics were contacted. The AD said staff did not update him on Resident #1's status before the outing and he was unaware that Resident #1 had a fall earlier in the day.The NHA and the director of nursing (DON) were interviewed together on 8/20/25 at 1:20 p.m. The NHA said the IDT reviewed every fall, the day after a fall occurred. The DON said the IDT was responsible for reviewing care plan interventions and updating residents' care plans when appropriate. The DON said she was unable to locate documentation of the IDT fall reviews, but she said she documented the risk reviews for each fall in the residents' EMR. The DON said Resident #1 liked to walk to the common area to socialize and arrange flowers. The DON said staff found the resident on the floor after her falls on 6/8/25 and 6/21/25 and the IDT determined Resident #1 had an unsteady balance. The DON said Resident #1 was educated to use her call light to ask for assistance from staff or to call out for assistance because call lights were not available in common areas. The DON said the IDT reviewed the 7/9/25 at 5:25 a.m. fall and determined the cause of the fall was because Resident #1 had poor safety awareness because she was carrying personal belongings while trying to ambulate with her walker to the common area. The DON said it was important for nurses to monitor residents after they had a fall in case the resident had any injury. She said residents that were being monitored after a fall should not attend outings away from the facility. The DON said Resident #4 went to an appointment at Walmart on 8/4/25 and was accompanied by her spouse. She said she was unable to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	locate who made the appointment and who arranged and approved for the spouse to provide transportation. The DON said the IDT did not review the fall because Resident #4 fell at a store, was treated by paramedics, and was transferred to the hospital. The DON said neurological assessments were completed after unwitnessed falls or when a resident had a head injury. The DON was unable to locate neurological assessments for the 8/4/25 fall. The NHA said he recalled discussing Resident #1 and Resident #4 after their falls but was unsure of corresponding recommendations made by the IDT. The NHA said the documentation of the reviews that were completed by the IDT were not documented in either residents' EMRs, but he had a daily log that indicated the reviews had occurred. The NHA said he was unable to find IDT documentation pertinent to falls for Resident #1 and Resident #4. The NHA said the IDT needed to improve documentation of clinical discussions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065193	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thornton Care Center	501 Thornton Pkwy Thornton, CO 80229

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain medical records in accordance with accepted professional standards and practices for one (#1) of two residents reviewed for medication documentation out of 14 sample residents.Specifically, the facility failed to ensure Resident #1's electronic medical record (EMR) contained complete and accurate documentation related to the administration of the resident's scheduled levetiracetam (a medication used to treat epilepsy, a seizure disorder) medication.Findings include:I. Facility policy and procedureThe Administering Medications policy, dated 8/4/25, was provided by the nursing home administrator (NHA) on 9/2/25 at 11:05 a.m. The policy read in pertinent part, Medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted may prepare, administer, and document the administration of medications. Record the results of medications administered per facility policy and procedure. Each time a medication is administered it must be documented.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE], discharged to the hospital on 7/9/25, and was readmitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included epilepsy (a seizure disorder), neurocognitive condition without behavioral disturbance, unspecified intracranial injury with loss of consciousness, insomnia, osteoarthritis, sacrum (pelvic) fracture and history of falling.The 4/24/25 minimum data sets (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident was independent from staff assistance for bed mobility, sitting and standing, transferring and walking with a walker.B. Record reviewReview of Resident #1's August 2025 CPO revealed the following physician's orders:Levetiracetam 1000 milligrams (mg) twice a day for seizures, administer at 6:00 a.m. and 4:00 p.m., ordered on 6/5/25.A review of Resident #1's July 2025 (from 7/1/25 to 7/31/25) medication administration record (MAR) revealed that a code of 9 was documented for the administration of levetiracetam on 7/8/25 and 7/9/25. According to the MAR, the code of 9 indicated other/see progress notes.-A review of Resident #1's progress notes on 7/8/25 and 7/9/25 failed to reveal documentation to indicate whether or not the levetiracetam medication was administered to the resident as ordered on those dates.III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 9/2/25 at 4:27 p.m. LPN #1 said he was the nurse assigned to administer medications to Resident #1 on 7/8/25 and 7/9/25. He said he documented a code of 9 for the resident's levetiracetam on both of those dates because he had been unable to locate the medication in order to administer it. He said on 7/8/25 and 7/9/25, another nurse had been able to find the medication in the facility's supply of emergency medications. LPN #1 said he had administered the medication to Resident #1 after receiving the doses from the nurse. LPN #1 said he should have documented a corresponding progress note in the EMR after the medication was administered. The director of nursing (DON) was interviewed on 8/25/25 at 4:27 p.m. The DON said LPN #1 should have documented a corresponding progress note in the EMR after Resident #1's levetiracetam was administered on 7/8/25 and 7/9/25. The DON said LPN #1 was a new employee at the facility and he had been unsure how to document that the medication was administered after he had already entered a code of 9 on the MAR.