STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065401	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Stonegate	15720 Garden Plaza Dr Parker, CO 80134

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to develop and implement a baseline care plan for within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs for two (#2 and #4) of three residents reviewed out of four sample residents. Specifically, the facility failed to:-Implement a baseline care plan that included fall prevention interventions in order to prevent a fall with major injury on 8/17/25 for Resident #2; and,-Implement a baseline care plan that included information for fracture care in order to properly care for Resident #2's admitting diagnoses of a right ankle fracture and right shoulder ligament repair and Resident #4's admitting diagnoses of thoracic spine and rib fractures.Findings include:I. Resident # 2A. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, right ankle fracture and right shoulder ligament repair and malnutrition.The 8/15/25 minimum data sets (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. The resident required partial to moderate assistance from staff for bed mobility and was dependent on staff for sitting and standing, transferring and using a manual wheelchair. B. Resident interviewResident #2 was interviewed on 8/20/25 at 12:10 p.m. Resident #2 said she fell when she tried to get out of bed in the morning (on 8/17/25). Resident #2 said was unhappy that she fell and fractured her wrist. Resident #2 said before she fell, she had her right foot in a brace and her right shoulder was already in a sling. Resident #2 said she fractured her right wrist when she fell on 8/17/25 and now had a cast on her right arm. Resident #2 said she was worried the cast on her right arm might interfere with her right shoulder healing after her recent shoulder surgery. Resident #2 said some staff were unaware how to care for her arm sling and leg brace. Resident #2 said some staff left her leg brace in place all night and some staff were unable to remove her arm sling to help her with dressing.C. Record reviewResident #2's baseline care plan, initiated 8/11/25, revealed Resident #2 was at risk for falls. -However, the baseline care plan did not include interventions for fall prevention.-The record review revealed there was not a baseline initiated for fracture care or shoulder care for Resident #2.The 8/17/25 at 3:30 p.m. nurse progress note revealed Resident #2 returned from the hospital following a fall and Resident #2's right wrist was in a splint due to a wrist fracture.Cross reference F689 for failure to prevent a fall with major injury.II. Resident #4 A. Resident statusResident #4, age greater than 65, was admitted on [DATE], discharged to the hospital on 8/19/25 and was readmitted on [DATE]. According to the August 2025 CPO, diagnoses included history of falling, history of stroke, muscle weakness, malnutrition, cognitive impairment, thoracic spine fracture, multiple fractures of ribs and back surgery on 8/1/25.The 8/7/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 10 out of 15. Resident #4 was dependent on staff for bed mobility and required substantial to (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maximum assistance from staff for standing. The resident was not evaluated for transfer assistance and mobility assistance needs.B. Resident interviewResident #4 was interviewed on 8/25/25 at 2:03 p.m. Resident #4 said staff were not careful with helping her move in bed and she worried about having increased pain in her back because staff were not careful when they assisted her. C. Record review -Review of Resident #4's baseline care plan revealed the care plan did not include interventions for spine fracture or spinal precautions following the resident's post-operative care following spine surgery while turning, repositioning or transferring the resident. III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 8/25/25 at 2:12 p.m. LPN #1 said when residents were admitted to the facility they were assessed to determine their risk for falling. LPN #1 said when a resident had a risk for falling, the admitting nurse completed a baseline care plan for fall prevention and initiated fall prevention interventions. LPN #1 said the fall prevention interventions were assigned to nurses and certified nurse aides (CNA) for monitoring and observations as indicated by the intervention. LPN #1 said when residents were identified as a high risk for falling, the fall risk information was included during the shift-to-shift report so that oncoming staff were able to identify which residents had a high risk of falling. LPN #1 said she was unable to find any baseline care plan interventions for Resident #2 and Resident #4 pertaining to caring for their fractures and immobilized joints.CNA #1 was interviewed on 8/25/25 at 2:30 p.m. CNA #1 said she was informed about residents with recent falls, injuries and special care needs during the shift-to-shift reports. CNA #1 said she was unaware of specialized care needs for Resident #2 and Resident #4 when she assisted with transfers and positioning of the residents. CNA #1 said she assisted Resident #2 with applying her orthopedic ankle brace but she did not know what to assess to ensure the brace was applied correctly. CNA #1 said she was careful with all the residents. The director of nursing (DON) was interviewed on 8/25/25 at 3:03 p.m. The DON said when residents were admitted to the facility, they had a fall risk assessment completed by the admitting nurse and were assigned a fall risk score. The DON said that every resident with a score of 10 and above was considered to be a fall risk and should have a care plan initiated with interventions to reduce falls or prevent serious injury if a fall occurred. The DON said Resident #2 had a high risk for falling and should have had interventions initiated upon admission to prevent falls.The DON said nurses should check and assess residents that had fractures for swelling, circulation and check devices (braces/spints) for safety and proper use. The DON said Resident #4 should have had spinal precautions in place on her baseline care plan. The DON said she was unable to locate baseline care plans for Resident #2 and Resident #4's fracture 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 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 (#2 and #4) three residents reviewed for accidents and hazards received adequate supervision to prevent accidents out of four sample residents.Resident #2, who had severe cognitive impairment, was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, a right ankle fracture and right shoulder ligament repair following a fall at home. The resident's right ankle was immobilized in an orthopedic boot and her right arm was immobilized in a sling. The facility identified upon admission that the resident was a high risk for falling and initiated a baseline fall care plan. However, the baseline fall care plan failed to include interventions to prevent falls for the resident. On 8/17/25 Resident #2 sustained a fall in her room and complained of right wrist pain. The physician ordered an Xray of the resident's wrist to be completed at the facility and the resident was diagnosed with a right wrist fracture. Resident #2 was transferred to the emergency department for further evaluation of her right wrist fracture.Additionally, Resident #4, who had moderate cognitive impairment, was admitted to the facility on [DATE] with diagnoses that included a history of falling, a history of stroke, muscle weakness, malnutrition, cognitive impairment, thoracic spine fracture, and multiple fractures of ribs and post-back surgery on 8/1/25. The facility initiated a fall care plan on 8/5/25 with interventions that included placing the call light within the resident's reach and assisting the resident with activities of daily living (ADL). However, observation and resident interview during the survey revealed Resident #4 was unable to demonstrate that she could locate and activate her call light to call for staff assistance. On 8/19/25, Resident #4 sustained a fall in her room and was bleeding from her head. The resident was sent to the hospital for evaluation and was diagnosed with an open skull fracture.Resident #4 was readmitted to the facility on [DATE] and the facility implemented a fall intervention for the resident to wear gripper socks. Specifically, the facility failed to:-Implement a baseline care plan with effective fall prevention interventions in order to prevent a fall with major injury on 8/17/25 for Resident #2; and,-Implement appropriate person-centered and effective fall interventions in order to prevent a fall with major injury on 8/19/25 for Resident #4.Findings include:I. Facility policy and procedureThe Fall Management policy, revised 3/11/25, was provided by the nursing home administrator (NHA) on 8/25/25 at 10:36 a.m. It revealed in pertinent part, The facility will assess the resident upon admission, readmission, with a change in condition and with any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls. During the assessment, a care plan will be developed and initiated by the admitting nurse on any residents assessed to be at risk for falls. The interdisciplinary team (IDT) will review and revise the care plan if indicated upon a fall event. The interventions to reduce the risk of falls should be individualized based on the resident risk factors and fall history.II. Resident # 2A. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, right ankle fracture, right shoulder ligament repair and malnutrition.The 8/15/25 minimum data sets (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. The resident required partial to moderate assistance from staff for med mobility, was dependent on staff for sitting and standing, transferring and using a manual wheelchair. B. Resident interviewResident #2 was interviewed on 8/20/25 at 12:10 p.m. Resident #2 said she fell when she tried to get out of bed in the morning (on 8/17/25). Resident #2 said was unhappy that she fell and fractured her wrist. Resident #2 said before she fell, she had her right foot in a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	brace and her right shoulder was already in a sling. Resident #2 said she fractured her right wrist when she fell on 8/17/25 and now had a cast on her right arm. Resident #2 said she was worried the cast on her right arm might interfere with her right shoulder healing after her recent shoulder surgery.C. Record reviewResident #2's baseline care plan, initiated 8/11/25, revealed Resident #2 was at risk for falls. The care plan was not developed and did not include interventions for fall prevention.Cross-reference F655 for failure to initiate a thorough baseline care plan for fall prevention.The 8/11/25 Fall Risk Evaluation revealed Resident #2 had a fall risk score of 16, which indicated the resident had a high risk for falling.The 8/17/25 7:04 a.m. nurse progress note revealed Resident #2 was observed on the floor in her room. The resident's call light was not on and Resident #2 was leaning on the closet door with no shoes on. Resident #2 complained of severe pain in her right wrist. Staff assisted Resident #2 to her bed and the physician was notified about the fall. The physician ordered a mobile Xray of the wrist to be completed at the facility. The Xray was completed on 8/17/25 and revealed a wrist fracture. The physician was notified and Resident #2 was transferred to the hospital for evaluation and treatment of the right wrist fracture. The 8/17/25 3:30 p.m. nurse progress note revealed Resident #2 returned from the hospital and Resident #2's right wrist was in a splint due to a wrist fracture.The 8/17/25 fall investigation revealed Resident #2 did not have her call light on, wore one sock, and was unable to recall details of why and how she got out of her bed. The facility investigation determined the cause of the fall was Resident #2 got out of bed without assistance from staff. The 8/22/25 8:57 a.m. physician progress note revealed Resident #2 was evaluated by the orthopedic specialist and Resident #2 would require future surgery for the right wrist fracture. The orthopedic specialist ordered Resident #2 to continue wearing the right wrist splint and to encourage Resident #2 to complete finger and thumb range of motion exercises.On 8/25/25 the facility updated Resident #2's fall care plan that included placing fall mats on both sides of Resident 2's bed.-There was no documentation that Resident #2 was assessed for understanding that she could locate and activate a call light to request assistance when she wanted to get out of bed (see director of nursing (DON) interview below). -There was no care plan initiated for fracture care for Resident #2's fractured ankle and shoulder that were present at admission or for the wrist fracture sustained at the facility on 8/17/25.Cross-reference F655 for failure to initiate a baseline care plan for fracture care. III. Resident #4A. Resident statusResident #4, age greater than 65, was admitted on [DATE], discharged to the hospital on 8/19/25 and was readmitted on [DATE]. According to the August 2025 CPO, diagnoses included history of falling, history of stroke, muscle weakness, malnutrition, cognitive impairment, skull fracture, thoracic spine fracture, and multiple fractures of ribs and back surgery on 8/1/25.The 8/7/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 10 out of 15. Resident #4 was dependent on staff for bed mobility and required substantial to maximum assistance from staff for standing. The resident was not evaluated for transfer assistance and mobility assistance needs. B. Resident observation and interviewOn 8/25/25 at 2:03 p.m. Resident #4 was resting on her bed. She had a call light button within her reach. When asked, Resident #4 was unable to locate her call light and said she did not know if she would remember to use the call light to call staff. C. Record reviewResident #4's fall care plan, initiated 8/5/25, revealed the resident was at risk for falls. Interventions included assisting the resident with ADLs, placing the resident's call light in reach, orienting the resident to her room and completing a fall risk assessment.The 8/22/25 Fall Risk Evaluation revealed Resident #4 had a fall risk score of 22, which indicated the resident had a high risk for falling.The 8/19/25 at 11:04 a.m. nurse progress note revealed Resident #4 fell and was found on the floor near her bed and was bleeding from her head (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nurse documented Resident #4 remained conscious and was assisted to her bed until she was transferred to the hospital.The 8/19/25 fall investigation revealed Resident #4 was found on the floor next to her bed and was bleeding from a laceration on the back of her head. Staff provided first aid, called 911, and Resident #4 was transferred to the emergency department for evaluation. Resident #4 was diagnosed with an open skull fracture, and returned to the facility on 8/22/25. The facility investigation determined the cause of the fall was the resident got out of bed without assistance when the resident believed it was time to get out of bed for the day. The 8/22/25 hospital summary documented that Resident #4 was diagnosed with an open fracture of the temporal (skull) bone and was at her usual level of cognition.On 8/22/25 the facility updated Resident #4's fall care plan that included wearing grip socks at all times.-There was no documentation that Resident #4 was assessed for understanding that she could locate and activate a call light to request assistance when she wanted to get out of bed (see DON interview below). IV. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 8/25/25 at 2:12 p.m. LPN #1 said when residents were admitted to the facility they were assessed to determine their risk for falling. LPN #1 said when a resident had a risk for falling, the admitting nurse completed a baseline care plan for fall prevention and initiated fall prevention interventions. LPN #1 said the fall prevention interventions were assigned to nurses and certified nurse aides (CNA) for monitoring and observations as indicated by the intervention. LPN #1 said when residents were identified as a high risk for falling, the fall risk information was included during the shift-to-shift report so that oncoming staff were able to identify which residents had a high risk of falling.CNA #1 was interviewed on 8/25/25 at 2:30 p.m. CNA #1 said she knew which residents were at risk for falling because she was familiar with the residents on her assigned unit. CNA #1 said she thought every resident had a risk of falling and she made sure residents had their call lights and personal items within their reach. CNA #1 said she was informed about residents with recent falls, injuries and special care needs during the shift-to-shift reports. The DON was interviewed on 8/25/25 at 3:03 p.m. The DON said when residents were admitted to the facility, they had a fall risk assessment completed by the admitting nurse and were assigned a fall risk score. The DON said that every resident with a score of 10 and above was considered to be a fall risk and should have a care plan initiated with interventions to reduce falls or prevent serious injury if a fall occurred. The DON said Resident #2 had a high risk for falling and should have had interventions initiated upon admission to prevent falls.The DON said Resident #4 had a fall risk score of 22 and had a high risk for falling. The DON said Resident #4 was confused and wanted to get out of bed earlier and get dressed earlier than her normal routine. The DON said when residents were admitted to the facility, they were oriented to their rooms and received instruction regarding where their call lights were located and residents were asked to demonstrate that they could press the button to call for assistance. -However, Resident #4 was unable to locate her call light during observation and said she did not know if she would remember to use the call light to call staff (see observation above).The DON said the room and call light orientation did not include specific steps to ensure a cognitively impaired resident retained understanding and could later locate and activate the call light without staff assistance.