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	04/08/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to prevent misappropriation of property for one (#7) of three residents reviewed for misappropriation of personal property out of 18 sample residents.Specifically, the facility failed to prevent the theft of Resident #7's narcotic medication card containing 89 pills.Findings include:I. Facility policy and procedureThe Abuse Prevention and Reporting policy, reviewed March 2026, was provided by the nursing home administrator (NHA) on 4/7/26 at 1:00 p.m. It revealed in pertinent part, Residents will be free from verbal abuse, physical abuse, mental abuse, sexual abuse, involuntary seclusion, neglect and exploitation. Exploitation-any occurrence involving misappropriation of a resident's property (deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, a resident's belongings or money without the resident's consent).The Drug Diversion Reporting and Response policy and procedure, revised 3/16/24, was provided by the NHA on 4/8/26 at 3:15 p.m. It revealed in pertinent part, Drug diversion is using or taking possession of a prescription medication or medical gas from residents' prescriptions and E-Kit (emergency kit for medication) intentionally and without proper authorization. Suspicion of drug diversion may arise from a variety of circumstances, including, but not limited to the following: suspicious activity identified during routine monitoring and/or proactive surveillance, and self-disclosure of drug diversion by an individual.II. Resident #7A. Resident statusResident #7, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included muscle wasting and atrophy, age-related osteoporosis, wedge compression fracture T11-T12 (thoracic) vertebra (back bone) and muscle weakness. The 3/31/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment revealed Resident #7 experienced pain on occasion and had as needed (PRN) pain medication ordered. B. Resident interviewResident #7 was interviewed on 4/7/26 at 10:05 a.m. Resident #7 said he experienced daily pain that was managed by daily scheduled pain medication. He said when the pain was worse, he would ask for his PRN oxycodone (opioid medication for moderate to severe pain). Resident #7 said he had not had any issues receiving this medication when he asked for it. However, he said he remembered a time when he asked for it and was told there was not any in the building for him, which he said he thought was strange because he did not take it very often. C Record ReviewReview of Resident #7's April 2026 CPO revealed the following physician's order: Oxycodone HCL oral tablet 5 milligrams (mg) by mouth every 8 hours as needed for pain three times a day PRN, ordered on 12/24/24. Review of Resident #7's December 2025 medication administration record (MAR) revealed the resident had requested oxycodone on 12/29/25 for a pain rating level of 7 out of 10. The December 2025 MAR documented the resident had received the PRN oxycodone on 12/29/25. The facility's drug diversion investigation, dated 12/31/25, was provided by the NHA on 4/7/26 at approximately 2:00 p.m. The investigation included written statements from the involved staff members, the incident write up by the NHA, and a written narrative of a meeting, dated 1/2/26, between the NHA, the director of nursing (DON), the human resources representative and licensed practical nurse (LPN) #4. Documents from the investigation revealed (LPN) #4 had been in the facility on 12/26/25, her day off, and had looked up (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two residents in the facility's electronic charting system who were on oxycodone, including Resident #7.Registered nurse (RN) #5's written statement, dated 1/2/26, documented that RN #5, as the offgoing shift nurse on 12/26/25, completed the medication narcotic count with LPN #4, even though LPN # 4 was not the oncoming shift nurse on 12/26/25. RN #5 documented on the narcotic count sheet that there were 24 narcotic cards in the medication cart.The 12/26/25 written statement by LPN #3, the oncoming shift nurse on 12/26/25, documented she counted the narcotic cards by herself and identified a discrepancy between the narcotic card count and the number on the narcotic count sheet from the morning of 12/26/25. LPN #3's statement indicated she changed the number on the narcotic count sheet to match the narcotic card count.LPN #4's written statement, dated 12/29/25, documented that she had been in the building on 12/26/25 and counted with the offgoing shift nurse, RN #5, in order to relieve RN #5 early and then LPN #4 gave the keys to the medication cart to LPN #3. The investigation revealed LPN #3 worked again on 12/29/25 when Resident #7 asked for his PRN oxycodone pain medication. LPN #3 could not find Resident #7's narcotic card in the medication cart. LPN #3's written statement, dated 12/26/25, documented when LPN #3 counted the narcotic cards on 12/21/25, there had been an oxycodone medication card for Resident #7 in the medication cart. On 1/2/26 the NHA, the DON, the human resources representative and LPN #4 met. The human resources representative's written statement, dated 1/2/26, documented that LPN #4 admitted to taking Resident #7's oxycodone medication card from the medication cart on 12/26/25. LPN #4 was relieved of her duties and escorted off the premises at that time. III. Staff interviewsThe assistant director of nursing (ADON) and the NHA were interviewed together on 4/7/26 at approximately 5:10 p.m. The ADON said the missing card of Resident #7's oxycodone pain medication was not discovered until 12/29/25, when Resident #7 requested a dose of PRN oxycodone for his pain. The ADON said the medication nurse, LPN #3, was aware that Resident #7 had a card of oxycodone in the medication cart but could not find it when the resident requested a dose on 12/29/25. The ADON said LPN #3 notified the DON at that point. The ADON said nurses should not count the medications on the cart alone. The ADON said the professional standard of practice for narcotics counting was for the oncoming/offgoing shift nurses to complete the narcotics count together and sign off on the narcotic count sheet. She said if there was a discrepancy in the narcotic count, the nurse in charge or the DON would be notified immediately. The ADON said there would be documentation if a narcotic card had been used up or discontinued. She said there was no documentation for Resident #7's oxycodone card to be missing. LPN #3 was interviewed on 4/8/26 at 9:40 a.m. LPN #3 said she was the oncoming shift nurse on 12/26/25. She said a nurse manager, LPN #4, provided her with the keys to the medication cart but did not count the narcotics with her. LPN #3 said she counted by herself and noticed a discrepancy between the written number of narcotic cards and the actual count for the narcotic cards and changed the number on the narcotic sheet so the counts would match. She said she did not notify anyone of the discrepancy at the time she discovered it. LPN #3 said on 12/29/25, Resident #7 asked for a PRN dose of oxycodone and she knew he had a medication card for oxycodone, but she could not find it on 12/29/25. She said she went to the emergency medication supply to pull an oxycodone to give to Resident #7. She said she notified the DON of the discrepancy on 12/29/25. LPN #3 said the nurses were not to leave the medication cart without counting the narcotic medications with the oncoming shift nurse. She said both nurses were supposed to sign the narcotic count sheet and if there was a discrepancy in the narcotics count, then the DON should be notified immediately. RN #5 was interviewed on 4/8/26 at 4:04 p.m. RN #5 said she was the offgoing nurse on 12/26/25. She said LPN #4 had come to the building to relieve her early, although LPN #4 was not on duty that day. RN #5 said she counted the narcotics with LPN #4, who was her supervisor, and signed the narcotic count sheet, however; LPN #4 did not sign the narcotic count sheet. LPN #4 was interviewed at 4:12 p.m. LPN #4 said she did enter the building early on 12/26/25 even though it was her day off. She said she did count the narcotics with the offgoing shift nurse (RN #5), but did not sign the narcotic count sheet. LPN #4 said she took Resident #7's oxycodone medication card from the medication cart the morning (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 12/26/25. LPN #4 said she admitted to taking Resident #7's oxycodone medication from the medication cart that day (12/26/25) to the NHA and the DON on 1/2/26.