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	08/07/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on record review and interviews, the facility failed to ensure three (#1, #2 and #3) of five residents received treatment and care in accordance with professional standards of practice out of five sample residents. Specifically, the facility failed to administer pain medications in a timely manner per the physician orders for Resident #1, Resident #2 and Resident #3. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), E.[NAME], St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. II. Facility policy and procedure (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication Administration policy and procedure, dated 2/29/24, was received from the director of clinical services (DCS) on 8/7/24 at 5:15 p.m. It revealed in pertinent part, Resident medications are administered in accurate, safe, timely and sanitary manner. Physician Orders-Medications are administered in accordance with written orders of the attending physicians or physician extender. Verify the medication label against the medication administration record (MAR) for accuracy of drug frequency, duration, strength and route. III. Resident #3 A. Resident status Resident #3, age less than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses include fracture of the right fibula (broken bone of the lower leg), chronic obstructive pulmonary disease (abnormal oxygen exchange), type 2 diabetes (abnormal glucose) and schizoaffective disorder (mental disorder). The 7/1/24 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 assessment indicated Resident #3 received pain medications scheduled and as needed. B. Resident interview Resident #3 was interviewed on 8/7/24 at 3:15 p.m. Resident #3 said her medications were rarely administered on time. Resident #3 said she had not received her morning medications today (8/7/24) until almost 11:00 a.m (see record review below). She said her night time pain medications on 8/6/24 were not administered to her until around 10:00 p.m (see record review below). Resident #3 said she had been educated by the facility staff that her pain medications needed to be scheduled and on time to achieve the best pain control. Resident #3 said she had submitted a couple of formal grievances to the facility concerning her medications being given late (see record below) and she had instructed the facility to tell staff to wake her if medications were due to be administered so she could ensure she got them as ordered. C. Resident grievances On 6/5/24 Resident #3 filed a grievance form related to missing medications.The form documented she did not receive her medications because the nurse failed to wake her to administer them. The facility follow up indicated the facility obtained a physician's order to wake the resident for all scheduled medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 filed a second grievance form on 7/2/24 related to medications being administered late. The form documented the resident complained about getting her medications two to three hours late. The facility representative spoke with Resident #3 about the timeliness of her medications. The facility followed up with the nurse who administered the medications late and the nurse was educated about the time window for medication administration. -However Resident #3 continued to receive her medications late (see administration records below). D. Record Review According to the August 2024 CPO Resident #3 had the following physician's order for pain management: Morphine sulfate ER (extended release) (opioid pain medication) 15 milligrams (mg), administer 45 mg two times a day, ordered 6/30/24. Hydrocodone-Acetaminophen (opioid pain medication) 10-325 mg twice daily, ordered 6/27/24. Acetaminophen (pain medication) 1000 mg three times daily, ordered on 6/27/24. According to the August 2024 medication administration record (MAR), Resident #3's morphine sulfate was to be administered at 8:00 a.m. and 8:00 p.m. -On 8/1/24 the 8:00 a.m. administration was administered at 9:49 a.m., 49 minutes after the allowed medication administration window. On 8/1/24 the administration times for the morphine sulfate were changed to 6:00 a.m and 7:00 p.m. per the August 2024 MAR. Review of the morphine sulfate administrations documented on the August 2024 MAR revealed the following: -On 8/1/24 the 7:00 p.m. dose was administered at 8:40 p.m., 40 minutes after the allowed medication administration window; -On 8/2/24 the 6:00 a.m. dose was administered at 10:49 a.m., three hours and 49 minutes after the allowed medication administration window; -On 8/3/24 the 6:00 a.m. dose was administered at 7:46 a.m., 46 minutes after the allowed medication administration window; -On 8/4/24 the 6:00 a.m. dose was administered at 10:22 a.m., three hours and 22 minutes after the allowed medication administration window; -On 8/4/24 the 7:00 p.m. dose was administered at 10:26 p.m., two hours and 26 minutes after the allowed medication administration window; -On 8/5/24 the 6:00 a.m dose was administered at 8:00 a.m., one hour after the allowed medication administration window; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/6/24 the 7:00 p.m. dose was administered at 9:10 p.m., one hour and 10 minutes after the allowed medication administration window; and, -On 8/7/24 the 6:00 a.m. dose was administered at 10:45 a.m. three hours and 45 minutes after the allowed medication administration window. The August 2024 MAR revealed Resident #3's hydrocodone-acetaminophen was scheduled to be administered at 6:00 a.m. and 4:00 p.m. Review of the hydrocodone-acetaminophen administrations documented on the August 2024 MAR revealed the following: -On 8/1/24 the 6:00 a.m. dose was administered at 9:49 a.m., two hours and 49 minutes after the allowed medication administration window; -On 8/1/24 the 4:00 p.m. dose was administered at 5:22 p.m., 22 minutes after the allowed medication administration window; -On 8/2/24 the 4:00 p.m. dose was administered at 6:05 p.m., one hour and five minutes after the allowed medication administration window; -On 8/3/24 the 6:00 p.m. dose was administered at 7:46 a.m., 46 minutes after the allowed medication administration window; -On 8/4/24 the 6:00 a.m. dose was administered at 10:22 a.m., three hours and 22 minutes after the allowed medication administration window; -On 8/4/24 the 4:00 p.m. dose was administered at 5:17 p.m., 17 minutes after the allowed medication administration window; -On 8/5/24 the 6:00 a.m. dose was administered at 8:00 a.m., one hour after the allowed medication administration window; and, -On 8/7/24 the 6:00 a.m. dose was administered at 10:47 a.m., three hours and 47 minutes after the allowed medication administration window. According to the August 2024 MAR, the scheduled administration times for Resident #3's acetaminophen 1000 mg were 9:00 a.m., 1:00 p.m. and 9:00 p.m. Review of the acetaminophen administrations documented on the August 2024 MAR revealed the following: -On 8/2/24 the 9:00 a.m. dose was administered at 10:18 a.m., 18 minutes after the allowed medication administration window; -On 8/2/24 the 1:00 p.m. dose was administered at 2:45 p.m., 45 minutes after the allowed medication administration window; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/4/24 the 9:00 a.m dose was administered at 10:15 a.m., 15 minutes after the allowed medication administration window; -On 8/4/24 the 9:00 p.m. dose was administered at 10:25 p.m., 25 minutes after the allowed medication administration window; and, -On 8/7/24 the 9:00 a.m. dose was administered at 10:41 a.m., 41 minutes after the allowed medication administration window. IV. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the August 2024 CPO, diagnoses include hemiplegia (inability to move one side of the body) affecting left side, dementia, type 2 diabetes, chronic pain and chronic obstructive pulmonary disease. The 7/18/24 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 indicated Resident #1 received scheduled pain medications and as needed pain medications. Resident #1 had pain almost constantly. B. Resident interview Resident #1 was interviewed on 8/7/24 at 2:05 p.m. Resident #1 said he was not sure when he would get pain medication as every nurse brought him medications at different times. C. Record review According to the August 2024 CPO, Resident #1 had the following physician's order for pain management: Acetaminophen 1000 mg three times a day for pain, ordered on 1/29/24. According to the August 2024 MAR, Resident #1's acetaminophen was scheduled to be administered at 9:00 a.m., 1:00 p.m. and 9:00 p.m. These administration times were discontinued on 8/2/24 after the 9:00 a.m. dose. On 8/2/24 the acetaminophen physician's order changed to administer the acetaminophen at 6:00 a.m., 11:00 a.m. and 7:00 p.m. Review of the acetaminophen administrations documented on the August 2024 MAR revealed the following: -On 8/2/24 the 11:00 a.m. dose was administered at 12:39 p.m., 39 minutes after the allowed medication administration window; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/3/24 the 6:00 a.m. dose was administered at 9:48 a.m., two hours and 48 minutes after the allowed medication administration window; -On 8/3/24 the 7:00 p.m. dose was administered at 10:59 p.m., two hours and 59 minutes after the allowed medication administration window; -On 8/4/24 the 6:00 a.m. dose was administered at 8:50 a.m., one hour and 50 minutes after the allowed medication administration window; -On 8/5/24 the 6:00 a.m. dose was administered at 8:26 a.m., one hour and 26 minutes after the allowed medication administration window; -On 8/5/24 the 11:00 am dose was administered at 1:04 p.m., one hour and four minutes after the allowed medication administration window; -On 8/5/24 the 7:00 p.m. dose was administered at 10:46 p.m., two hours and 46 minutes after the allowed medication administration window; -On 8/6/24 the 6:00 a.m. dose was administered at 8:03 a.m., one hour and three minutes after the allowed medication administration window; -On 8/6/24 the 11:00 a.m. dose was administered at 12:32 a.m., 32 minutes after the allowed medication administration window; -On 8/7/24 the 6:00 a.m. dose was administered at 10:54 a.m., three hours and 54 minutes after the allowed medication administration window; and, -On 8/7/24 the 11:00p a.m. dose was administered at 1:13 p.m., one hour and 13 minutes after the allowed medication administration window. V. Resident #2 A. Resident status Resident #2, age than 65, admitted on [DATE]. According to the August 2024 CPO, diagnoses include dysphagia (impaired swallowing) following cerebral infarction (disrupted blood flow to the brain), hemiplegia affecting the right side, dementia and hypertension (increased blood pressure). The 7/24/24 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of nine out of 15. The MDS assessment indicated the resident had pain almost constantly. The resident had received scheduled pain medications and as needed pain medication. B. Record Review According to the August 2024 CPO, Resident #2 had the following physician's order for pain management: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tramadol (pain medication) 50 mg once daily, ordered on 8/2/24. According to the August 2024 MAR, Resident #2's tramadol was to be administered at 6:00 a.m. Review of the tramadol administrations documented on the August 2024 MAR revealed the following: -On 8/3/24 the 6:00 a.m. dose was administered at 7:53 a.m., 53 minutes after the allowed medication administration window; -On 8/4/24 the 6:00 a.m. dose was administered at 10:34 a.m three hours and 34 minutes after the allowed medication administration window; -On 8/5/24 the 6:00 a.m. dose was administered at 9:41 a.m., two hours and 41 minutes after the allowed medication administration window; -On 8/6/24 the 6:00 a.m. dose was administered at 7:18 a.m.,18 minutes after the allowed medication administration window; and, -On 8/7/24 the 6:00 a.m. dose was administered at 10:58 a.m., three hours and 58 minutes after the allowed medication administration window. VI. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 8/7/24 at 4:42 p.m. LPN # 1 said scheduled pain medications should be given timely. She said pain medications needed to be administered within one hour before or one hour after the scheduled administration time for effective pain management. LPN #1 said it was hard to control breakthrough pain. LPN #1 said she would call the physician to make sure it was okay to administer the medication outside of the time frame and document in a progress note. -However, review of Resident #1, Resident #2 and Resident #3's EMRs did not include documentation indicating the physician had been contacted for any medications given outside of the safe administration time. LPN #2 was interviewed on 8/7/24 at 4:46 p.m. LPN #2 said pain medications should be administered as scheduled. She said it was important to administer pain medications as ordered to help manage pain. LPN #2 said medications needed to be given within one hour before or one hour after the scheduled time. LPN #2 said the physician should be called to make sure it was safe for the medications to be given late. The DCS was interviewed on 8/7/24 at 6:00 p.m. The DCS said pain medications should be administered as scheduled for effective pain management. The DCS said pain medication given late or early could be problematic for a resident by not being effective to control pain or that the resident may have too much medication in their system. The DCS said the physician should be notified if the medication was given outside the safe administration window. (continued on next page)

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