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	04/01/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on record review and interviews, the facility failed to ensure residents were kept free from abuse for two (#2 and #5) of three residents reviewed for abuse out of six sample residents. Specifically, the facility failed to: -Protect Resident #2 and Resident #5 from sexual abuse by Resident #3; and, -Ensure staff report an incident of sexual abuse in a timely manner. Findings include: I. Facility policy and procedure The Abuse policy, revised 2/29/24, was provided by the nursing home administrator (NHA) on 4/1/25 at 10:00 a.m. It read in pertinent part, Sexual abuse is non-consensual sexual contact of any type with a resident. If resident abuse, neglect, or exploitation is suspected, the suspicion must be reported immediately to the administrator. The facility conducts an internal investigation. While the investigation is ongoing, the alleged assailant has interventions implemented to help ensure the safety of the alleged victim as well as other residents. The investigation includes interviewing any staff members, residents or family members who may have knowledge of the incident. II. Incident of sexual abuse of Resident #2 by Resident #3 on 1/1/25 A. Facility investigation (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation revealed that on 1/2/25 Resident #2 reported that on 1/1/25, Resident #3 lifted his shirt when she passed him in the hallway. She said he lifted his shirt and his genitals were exposed. Resident #2 said Resident #3 was making her very uncomfortable and he was laughing and smiling while exposing himself. Resident #2 said her roommate, Resident #5, told Resident #3 to leave Resident #2 alone. Resident #2 said she was trying to stay away from Resident #3 because he made her uncomfortable and he left his pants unzipped so when he lifted his shirt his penis was exposed. Resident #3 was interviewed by the facility on 1/2/25 and he denied lifting his shirt around other residents or exposing his genitals. The facility interviewed additional residents and staff and there were no witnesses to Resident #3's behavior and no other residents were concerned with their safety or expressed fear of Resident #3. The facility unsubstantiated the abuse because there were no witnesses and Resident #3 denied the allegation. -However, abuse occurred as Resident #2 and Resident #5 (see interview below) both said Resident #3 had a history of exposing his penis to them on multiple occasions. -Additionally, it was identified on Resident #3's care plan, revised 9/20/24, that he had a history of masturbating and exposing himself in public (see care plan below). B. Resident #3 (assailant) 1. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included Wernicke's encephalopathy (brain disorder), alcohol induced dementia and impulse disorder. The 2/28/25 minimum data set (MDS) assessment revealed Resident #3 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The MDS assessment indicated the resident had physical behavioral symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing and abusing others sexually) on one to three days during the assessment review look-back period. 2. Record review Resident #3's impulse control care plan, revised 9/20/24, documented Resident #3 had the potential to be verbally aggressive, flip people off, masturbate in public spaces and show his privates (penis) to female residents and staff. Interventions included administering medications as ordered, analyzing triggers, assessing for sensory deficits, anticipating the resident's needs, giving the resident as many choices as possible about care and activities, monitoring observed behaviors and monitoring signs of the resident posing danger to himself or others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility failed to have person-centered interventions to keep Resident #3 from exposing himself to others. C. Resident #2 (victim) 1. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included stage 4 chronic kidney disease, depression, dependence on supplemental oxygen, acute on chronic diastolic (congestive) heart failure and difficulty walking. The 3/17/25 MDS assessment revealed Resident #2 was cognitively intact with a BIMS score of 13 out of 15. 2. Resident interview Resident #2 was interviewed on 3/31/25 at 3:15 p.m. Resident #2 said Resident #3 often stood in his bedroom doorway with the door and privacy curtain open. She said Resident #3 would lift his shirt and expose his penis when she walked by his room. Resident #2 said Resident #3 exposed himself to her numerous times and when she reported it to a staff member, she was told the staff would talk to Resident #3 but she said nothing ever came from it and Resident #3 continued to expose himself to her. Resident #2 said she was scared and did not feel safe and comfortable around Resident #3. Resident #2 said Resident #3 was a few doors down around the corner and she said she faced the wall whenever she walked to the dining room so she could not see anything Resident #3 was doing. Resident #2 said she feared that Resident #3 would escalate and do something more and the facility was not keeping her safe. III. Resident #5 (victim) A. Resident status Resident #5, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included respiratory failure with hypoxia (low oxygen in the blood), schizoaffective (mental illness) disorder, acute right heart failure and anxiety. The 3/28/25 MDS assessment revealed Resident #5 had moderate cognitive impairment with a BIMS score of 12 out of 15. B. Resident interview Resident #5 was interviewed on 3/31/25 at 3:20 p.m. Resident #5 said Resident #3 often stood in his bedroom doorway with the door and privacy curtain open. She said Resident #3 would lift his shirt and expose his penis when she walked by his room. Resident #5 said Resident #3 exposed himself to her numerous times and when she reported it to a staff member, she was told the staff would talk to Resident #3 and she said nothing ever came from it. Resident #5 said the incidents made her uncomfortable and mad. Resident #5 said she told Resident #3 she would chop it off and Resident #3 laughed at her. She said Resident #3 always laughed or smiled while exposing himself and it was disgusting. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Staff interviews The activity assistant (AA) was interviewed on 3/31/25 at 4:10 p.m. The AA said she was aware that Resident #2 had reported that Resident #3 exposed himself to her in January 2025. She said she overheard Resident #2 telling another resident that Resident #3 exposed himself to her the first week of February 2025. The AA said she did not report what she overheard Resident #2 say in February 2025 to management because Resident #2 giggled about the situation and did not seem upset. The activity director (AD) was interviewed on 3/31/25 at 4:15 p.m. The AD said he had seen Resident #3 in his room with the door open, exposing himself. The AD said he did not report it because the resident was in his room, but he said he probably should have reported it because if he could see Resident #3, that meant other residents could too. The NHA, corporate consultant (CC) #1 and CC #2 were interviewed together on 3/31/25 at 3:42 p.m. The NHA said Resident #2 reported the situation to a staff member and there was a little delay in the incident being reported to the NHA. He said he provided the staff education on reporting abuse allegations to management. He said Resident #2 and Resident #3 were separated and placed on frequent checks and other residents were interviewed to see if anyone else saw what happened. He said Resident #5 was not interviewed during the investigation because the incident occurred in the dining room and she was not there when it happened. The NHA said the allegation was unsubstantiated because a witness was not able to be located. The NHA said he was unaware the incident was still occurring, but he said he would start a new investigation, based on Resident #2 and Resident #5's comments (see resident interviews above). He said he was going to move Resident #3 to a room away from Resident #2 and Resident #5 to make them more comfortable. Certified nurse aide (CNA) #1 was interviewed on 4/1/25 at 12:10 p.m. CNA #1 said Resident #3 had behaviors that included showing his penis to others. CNA #1 said she was unsure of any interventions in place to prevent Resident #3 from exposing himself to others, but she said she could check the care plan, if needed, for interventions. -However, Resident #3's care plan failed to include interventions to prevent the resident from exposing his genitals to others (see care plan above). The NHA and CC #1 were interviewed together again on 4/1/25 at 12:15 p.m. The NHA said he started an investigation immediately after being informed Resident #3 continued to expose himself to Resident #2 and Resident #5. The NHA said all of the residents in the facility were interviewed and no one else had concerns about Resident #3 or reported witnessing the resident exposing himself to others. The NHA said the staff were asked to remind Resident #3 to zip-up in the dining room. -However, Resident #2 and Resident #5 said Resident #3 exposed his genitals to them on multiple occasions when they were walking in the hallway, not in the dining room (see resident interviews above).