

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER Thornton Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**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 procedure The 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. Observations On 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 interviews Resident #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 review A 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 interviews Licensed practical nurse (LPN) #1 was interviewed on 8/19/25 at 1:10 p.m. LPN #1 said the room temperatures 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.</p>		

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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. (continued on next page)

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**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 equipment/scooter to prevent Resident #4 from falling from the scooter while at an appointment. Findings include: I. Facility policy and procedure The 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</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**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:</p> <p>I. Facility policy and procedure The 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.</p> <p>II. Resident #1A. Resident status Resident #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.</p> <p>B. Record review Review 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.</p> <p>III. Staff interviews Licensed 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.</p>		