STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065358	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Westminster	7751 Zenobia CT Westminster, CO 80030

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards for one (#1) of three residents out of eight sample residents.Resident #1, who had a history of falls and previous fractures that included a right humerus (long bone in the upper arm) fracture, was admitted to the facility on [DATE]. On 3/1/26 at 3:30 a.m. Resident #1, who required maximum assistance from staff with transfers, fell out of bed. Registered nurse (RN) #1 heard a loud sound and found Resident #1 on the floor next to her bed lying on her left side in a somewhat fetal position partially on the fall mat. The bed was raised in a high position. RN #1's initial assessment revealed Resident #1's blood pressure was 184/95 millimeters of mercury (mmHg) and she had no injuries. (A normal blood pressure is generally below 120/80 mmHg). Neurological monitoring was initiated. The resident was placed back into bed without a thorough head to toe assessment completed. RN #1 failed to notify the director of nursing (DON), the physician, the responsible party and hospice at the time of the fall. Resident #1's blood pressure continued to rise and she was complaining of pain. At 6:00 a.m. RN #1 notified the hospice staff of the resident's increase in blood pressure and continued pain. The hospice RN arrived at the facility at 6:30 a.m. and assessed Resident #1. The hospice RN's assessment revealed the resident was aroused to verbal stimuli, she had tense features, facial grimacing and said she was in a lot of pain. The hospice RN notified the on-call physician and received a physician's order to send the resident to the hospital for evaluation and treatment.The hospital Xray results revealed Resident #1 had suffered a left parietotemporal scalp contusion (bruising to the side of the head), an acute nondisplaced fracture involving the C7 vertebra (lowest neck bone), multiple displaced rib fractures involving at least the first six ribs, left scapula (shoulder blade) fracture and left clavicle (collar bone) fracture.Specifically, the facility failed to:-Accurately and timely assess Resident #1 after she sustained a fall; -Notify the physician after Resident #1 experienced a fall that resulted in multiple fractures; -Monitor Resident #1 to ensure her bed was at a safe height; and,-Ensure Resident #1 was transferred to the hospital in a timely manner after an unwitnessed fall with major injury that resulted in pain. Findings include:I. Facility policy and procedureThe Incident and Reportable Event Management policy, revised 9/23/25, was provided by the nursing home administrator (NHA) on 3/19/26 at 1:20 p.m. It read in pertinent part,The facility to the best of its ability strives to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.The nurse evaluation should be completed prior to moving a resident who has fallen, to determine presence of injury. The assessment includes details of the resident (including location details of the resident), presence or absence of injury, and any treatments rendered. If a resident is able to report what occurred, this should be included in the notes. Notification of family or responsible party and notification of (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	physician and any orders received.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on 3/1/26. According to the March 2026 computerized physician orders (CPO), diagnosis included senile degeneration of the [NAME] (a progressive decline in memory, reasoning and judgement), bilateral (both) osteoarthritis of the knees, acute kidney failure, history of falling, muscle weakness and difficulty in walking.The 1/15/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 14 out of 15. She had impairment to both sides of her upper and lower extremities and used a wheelchair. She required maximal assistance from staff with toileting hygiene, bathing, upper and lower body dressing, putting on/off footwear, sitting to stand, chair to bed, toilet transfer and shower transfer. The assessment indicated she had one fall with no injury prior to the assessmentB. Resident #1's representative interviewResident #1's representative was interviewed on 3/18/26 at 11:32 am. The representative said Resident #1 had laid in her bed (on 3/1/26) for three hours in severe pain with no medical attention. She said the facility nurse did not notify the family or the physician of the fall. She said the hospice nurse was the one who notified the physician and the family. She said her family decided to place Resident #1 in a different facility after her discharge from the hospital following the fall. C. Record reviewThe fall care plan, initiated 6/30/25, revealed Resident #1 was at risk of falls related to daily antidepressant use and a history of falls. Interventions included assisting the resident with activities of daily living (ADL) as needed, placing a call don't fall sign in her room, placing a quick touch call light in the resident's room, placing the bed in the lowest position, ensuring a high impact fall mat was in place and providing a lipped mattress. A health status progress note, dated 3/1/26 at 6:10 a.m., documented following an unwitnessed resident fall from bed, neurological monitoring was initiated. The hospice agency was notified and the hospice nurse was called to assess Resident #1. The hospice nurse notified the physician of the the resident's status post-fall and the physician gave an order to send Resident #1 to the emergency room for evaluation and treatment. A health status progress note, dated 3/1/26 at 6:30 a.m., documented that at 3:30 a.m. RN #1 heard a sound like someone had fallen. RN #1 immediately went into the resident hallway and quickly discovered that the sound had come from Resident #1's room. Upon entering the room, RN #1 found Resident #1 on the floor on her left side in a somewhat fetal position, partially on and partially off the fall mat. The bed was raised up from the floor. -There was no documentation in the electronic medical record (EMR) to indicate that RN #1 completed a full head to toe assessment on Resident #1 when the resident was found on the floor. A communication with family progress note, dated 3/1/26 at 1:37 p.m., documented a voicemail was left with the resident's representative to discuss Resident#1's plan of care. A communication with family progress note, dated 3/1/26 at 1:57 p.m., documented the resident's representative returned the call and reported Resident #1 was being admitted to the intensive care unit related to fractures to her left ribs, a C7 neck fracture and a shattered (fractured) left shoulder. A communication with family progress note, dated 3/1/26 at 2:07 p.m., documented the resident's representative called to update the facility on Resident #1's situation. The resident's representative reported that Resident #1 had broken ribs to the entire left side, her left shoulder was shattered and she was being admitted to the trauma unit. On 3/1/26 Resident #1's blood pressure was documented as follows: -At 3:45 a.m. the blood pressure was 178/91 mmHg;-At 4:00 a.m. the blood pressure was 184/95 mmHg;-At 4:30 a.m. the blood pressure was 194/86 mmHg; and,-At 6:00 a.m. the blood pressure was 205/91 mmHg.III. Staff interviewsCertified nurse aide (CNA) #1 was interviewed on 3/19/26 at 10:22 a.m. CNA #1 said if a resident had a fall, she would immediately report the fall to the nurse. She said if the nurse was a licensed practical nurse (LPN), the LPN would immediately notify the RN to assess the resident for any injuries. She said the assessment must be completed before the resident could be moved. LPN #1 was interviewed on 3/19/26 at 10:29 a.m. LPN #1 said if a CNA reported a fall, she immediately reported it to the RN on duty so an assessment could be completed before moving the resident. She said vital signs were taken immediately, as well as neurological monitoring if the fall was (continued on next page)

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