

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Creekside Village Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 E Stuart St Fort Collins, CO 80525	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536</p> <p>Based on record review and interviews, the facility failed to ensure one (#13) of four residents investigated for abuse out of 13 sample residents was kept free from physical abuse.</p> <p>Specifically, the facility failed to protect Resident #13 from physical abuse by Resident #12.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse policy, revised on 6/11/24, was provided by the interim nursing home administrator (INHA) on 2/20/25 at 2:42 p.m. The policy read in pertinent part,</p> <p>Every resident has the right to be free from abuse. All occurrences of resident abuse shall be promptly reported to the abuse coordinator for investigation.</p> <p>The facility will ensure that all residents are protected during and after abuse investigations by:</p> <ul style="list-style-type: none"> -Responding immediately to protect the alleged victim; -Increasing supervision of the alleged victim and the other residents as indicated; and, -Providing emotional support to the resident during and after the investigation. <p>Sexual abuse is non-consensual contact of any type with a resident.</p> <p>II. Sexual abuse of Resident #13 by Resident #12</p> <p>A. Facility investigation</p> <p>(continued on next page)</p>

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 2/18/25 facility investigation was provided by the regional director of quality and compliance (RDQC) on 2/24/25 at 10:10 a.m. The investigation documented that on 2/18/25 at 11:45 a.m., registered nurse (RN) #1 observed Resident #12 kiss Resident #13 on her mouth. The facility staff responded immediately and separated the residents. RN #1 completed assessments on both residents and no injuries were apparent on either resident. Resident #13 told RN #1 that she was okay, said she did not like the kiss and understood that Resident #12 was confused.</p> <p>After the occurrence, both residents were placed on frequent monitoring for behavioral changes and were provided redirection to prevent reoccurrence. The facility investigation documented that Resident #12 had a history of making unwanted sexual advances toward other residents when agitated. Resident #12 was not interviewable during the facility investigation due to having severely impaired cognition. The facility investigation determined that no abuse occurred because both residents had cognitive memory impairment and neither resident had adverse effects.</p> <p>-However, sexual abuse occurred when Resident #12 kissed Resident #13 on the mouth without consent from Resident #13.</p> <p>III. Resident #12 - assailant</p> <p>A. Resident status</p> <p>Resident #12, age greater than 65, was admitted on [DATE]. According to the February 2025 computerized physician's orders (CPO), diagnoses included moderate dementia with other behavioral disturbance. Resident #12 resided in the memory care unit of the facility.</p> <p>The 11/30/24 minimum data set (MDS) assessment documented that Resident #12 had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The assessment documented the resident had no history of behaviors. Resident #12 was independent with ambulation.</p> <p>B. Record review</p> <p>The dementia care plan, revised on 9/20/23, identified that Resident #12 required placement in the secured unit for dementia. Interventions included providing scheduled activities within Resident #12's capabilities, keeping the resident's routine consistent with a consistent caregiver, presenting one thought at a time and using the resident's preferred name.</p> <p>The behavior care plan, revised on 11/6/23, revealed Resident #12 had a behavior problem and made unwanted sexual advances towards other residents. Interventions included assisting Resident #12 with more appropriate methods of coping and interacting, providing opportunity for positive interaction, giving Resident #12 space after waking up as she was disoriented when waking up, intervening as necessary to protect the safety of others, redirecting others, removing Resident #12 from a situation as needed, validating Resident #12's delusions and helping her find solutions to worries.</p> <p>The cognitive care plan, revised 9/20/23, identified Resident #12 as having impaired thought processes related to dementia. Interventions included administering medications as ordered, providing cueing, reminders, and guidance, providing the resident with a baby doll, validating delusions and engaging in simple, structured activities.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-A review of Resident #12's comprehensive care plan did not reveal any new person-centered interventions were implemented after Resident #12 kissed Resident #13 without consent in order to prevent a reoccurrence.</p> <p>The 2/18/25 at 1:37 p.m. nurse progress note documented Resident #12 displayed sexual behaviors towards another resident during the lunch meal and was removed from the dining room.</p> <p>The 2/18/25 at 3:29 p.m. nurse progress note documented Resident #12 entered the dining room and was observed trying to kiss Resident #13. Resident #13 tried to pull away from Resident #12. The nurse relocated Resident #12 near the nursing station for direct observation.</p> <p>The 2/18/25 social service progress note documented that Resident #12's family was notified of the occurrence and declined to transfer Resident #12 to an all-female locked unit.</p> <p>IV. Resident #13 - victim</p> <p>A. Resident status</p> <p>Resident #13, age greater than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included Alzheimer's disease and dementia of unspecified severity without behavioral disturbances.</p> <p>The 2/12/25 brief interview for mental status (BIMS) assessment indicated the resident had severe cognitive impairments with a score of two out of 15.</p> <p>B. Record review</p> <p>The dementia care plan, initiated on 2/12/25, identified Resident #13 had impaired thought processes related to her dementia diagnosis. Interventions included administering medications as ordered, cueing and reorienting as needed, discussing concerns about confusion and disease process, keeping Resident 13's routine consistent, monitoring and reporting changes in cognitive function and reviewing medications as a possible cause of cognitive deficit.</p> <p>The communication care plan, initiated 2/12/25, identified Resident #13 as having impaired communication related to her dementia diagnosis. Interventions included anticipating and meeting the residents needs, promoting placement in a room to promote communication with others, discussing concerns or feelings regarding communication difficulty, providing a safe environment and monitoring for nonverbal indicators of discomfort or stress.</p> <p>The 2/18/25 at 10:25 a.m. nurse progress note documented that Resident #12 put her arm around Resident #13's neck and kissed her on the mouth. Resident #13 pulled away from Resident #12 during the altercation. The nurse intervened and separated the residents.</p> <p>V. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RN #1 was interviewed on 2/3/25 at 1:15 p.m. RN #1 said she witnessed Resident #12 approach Resident #13 in the dining room and kiss Resident #13. RN #1 said she was in the dining room but could not intervene before Resident #12 kissed Resident #13 because Resident #12 walked quickly across the room and directly towards Resident #13. RN #1 said Resident #12 was agitated and had sexual behaviors during lunch because the unit had new staff members and had more noise and people in the unit than usual. RN #1 said she had been watching Resident #12 but could not intervene before Resident #12 kissed Resident #13 because she was across the room. RN #1 said that other residents on the unit became agitated when there was a change in routines and staff.</p> <p>RN #1 said she was not aware of any interventions for the unit when activity and routines were changing. RN #1 said there was one certified nurse aide (CNA) scheduled on the shift. She said sometimes there was also a programming assistant on the unit who helped monitor and observe the behavior of residents in the unit.</p> <p>RN #1 said she assessed and interviewed Resident #13 immediately after the kiss and said Resident #13 said she did not like the kiss but understood Resident #12 was confused. RN #1 said Resident #12 and Resident #13 were monitored after the occurrence. She said neither resident had changes to their mood or daily routine and continued to participate in group activities in the memory care unit.</p> <p>The RDQC was interviewed on 2/25/25 at 4:05 p.m. The RDQC said Resident #12 had no recent sexual behaviors. The RDQC said that on 2/18/25, the memory care unit had new staff members, which led to inconsistent routines, causing increased agitation for Resident #12. The RDQC said staff continued to monitor Resident #12 for sexual behaviors and there had been no repeat behaviors since 2/18/25.</p>		