STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065221	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Village Rehabilitation and Nursing LLC	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)
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** 52288 Based on observations, record review and interviews, the facility failed to ensure two (#10 and #13) of five residents out of 11 sample residents were kept free from abuse. Specifically, the facility failed to: -Protect Resident #10 from physical abuse by Resident #12; and, -Protect Resident #13 from verbal abuse by Resident #12. Findings include: I. Facility policy and procedure The Abuse, Neglect and Exploitation policy, dated 4/11/25, was provided by the nursing home administrator (NHA) on 5/13/25 at 5:59 p.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse. II. Incident of physical abuse between Resident #12 and Resident #10 on 3/29/25 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	The 3/29/25 facility abuse investigation, documented at 3:00 p.m., revealed that Resident #10 wandered into the room of Resident #12, which caused Resident #12 to become upset. Resident #12 said he began waving his fists at Resident #10, which caused Resident #10 to fall to the ground. Resident #12 had a puffy lip and said he may have accidentally hit himself while angrily waving his fists. The nurse on the unit assessed both residents. Resident #12 had a small puffy lip and denied any pain. Resident #10 had a small abrasion and bruise to his left pinky. Using the Pain Assessment In Advanced Dementia (PAINAD) scale, Resident #10 was assessed to have a pain level of 3, indicating mild pain. Resident #10's abrasion was cleaned. There were no witnesses who observed the incident. The investigation documented both residents had cognitive impairment. Resident #12 was interviewed by the NHA following the incident. Resident #12 said he did not like people wandering into his room. He said that he got angry and started moving his fists and was not sure if Resident #10 hit him or if he accidentally hit himself in the lip as he was moving his fists. He said he felt safe at the facility. Resident #10 was interviewed by the NHA and he said that he walked into a room and Resident #12 hit him and shoved him to the floor. Resident #10 said he felt okay and safe at the facility. The investigation documented the facility determined that there was contact made between the two residents that resulted in Resident #10 fell to the floor and all injuries were treated by nursing staff. The facility substantiated the physical abuse. The interventions put in place after the incident included encouraging direct line-of-sight supervision while awake for Resident #10 to prevent him from wandering into other residents' rooms. Staff were instructed to offer Resident #12 distractions, such as conversations about his family farm, time spent in Vietnam, guide him away from the altercation, allow him time to calm down and talk about other interests. The facility updated the care plans for both residents. B. Resident #10 - victim 1. Resident status Resident #10, age less than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included cerebral infarction unspecified (stroke), unspecified dementia, unspecified severity with other behavioral disturbance and bipolar disorder, current episode depressed severe without psychotic features. The 5/3/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. He required supervision or touching assistance with walking and was independent with self-propelling his wheelchair. He exhibited wandering behavior on a daily basis. The MDS assessment revealed the resident did not display physical behaviors directed towards others during the assessment look back period. 2. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The cognitive function care plan, initiated 8/9/24 and revised 11/4/24, documented Resident #10 had impaired cognitive functioning or impaired thought processes related to dementia. The care plan indicated that the resident had the potential for physical aggression with poor coping and problem solving abilities. Pertinent interventions included encouraging direct line of sight while the resident was awake to prevent wandering into other residents' rooms, maintaining a consistent daily routine and providing consistent caregivers as much as possible to help decrease confusion. The nursing progress note, dated 3/29/25, documented that Resident #10 wandered into another resident's room resulting in a physical altercation. The resident sustained a bruised finger and abrasion on the right hand. The resident was within normal limits and remained at baseline following the incident. C. Resident #12 - assailant 1. Resident status Resident #12, age 79, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included Parkinson's disease with dyskinesia without mention of fluctuations (a disease that causes involuntary movements) and amnesia (memory loss). The 3/23/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of six out of 15. He required partial or moderate assistance with the tasks of activities of daily living (ADL). The MDS assessment revealed the resident did not display physical behaviors directed towards others during the assessment look back period. 2. Record review The comprehensive care plan, initiated 3/31/25 and revised 5/13/25, documented Resident #12 had fluctuation in mood related to depression and Parkinson's disease. Pertinent interventions included redirecting the resident when he exhibited signs of agitation or was at risk of escalation, using calming and familiar conversational cues. Staff were instructed to engage the resident in discussions about meaningful life experiences. The nursing progress note, dated 3/29/25, documented Resident #12 displayed aggressive behaviors from 6:00 a.m. until shift change, including yelling, shaking his fist at other residents, and not tolerating individuals in his personal space. He remained angry throughout the day and was on 15-minute safety checks. III. Incident of alleged verbal abuse between Resident #12 and Resident #13 on 5/13/25 A. Observations (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 2:13 p.m., Resident #13 was propelling himself very slowly in a manual wheelchair, often stopping briefly and then continuing down the hallway in the secure unit. He was using the handrail with his right hand to pull himself along in his wheelchair. As he approached Resident #12's room, Resident #12 became visibly angry and yelled loudly at Resident #13, Get your hands off my door! Don't you dare go in there! Resident #12 shouted at the top of his lungs, drawing immediate attention to the incident. Resident #13 appeared visibly scared and confused following the incident, as evidenced by both arms trembling while he sat in his wheelchair. Registered nurse (RN) #3 immediately approached the two residents and asked Resident #12 if he wanted to go outside in the secured courtyard for a walk. He nodded yes and walked directly into the courtyard. At 2:19 p.m. Resident #12 stood outside the door and did not re-enter the unit. RN #3 opened the door and engaged him in conversation, however, Resident #12 refused to come back inside. At 2:20 p.m. RN #2 entered the secured unit and talked with Resident #13. RN #2 provided fidget tools to help calm him. RN #3 called the NHA who arrived in the unit at 2:21 p.m. to assist with de-escalation of Resident #12. At approximately 2:35 p.m. RN #2 left the secure unit. Resident #13 remained in the common area by himself, alternating between watching television and engaging intermittently with the fidget items. Resident #12 continued walking around in the courtyard until 3:10 p.m., at which time he knocked on the door and RN #3 let him back inside the unit. B. Facility investigation The 5/13/25 facility abuse investigation, documented at 2:20 p.m., revealed Resident #13 was observed walking down the hallway on the memory care unit and approached Resident #12's room. It appeared that Resident #13 touched the velcro stop sign that had been placed on the door of Resident #12, which caused Resident #12 to become angry and yell at Resident #13. The nurse reported hearing Resident #12 yell, Get your hands off my door! Don't you dare go in there. The nurse immediately separated and redirected the residents. There was no physical contact made between the two residents. C. Resident #13- victim 1. Resident status Resident #13, age 75, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included neurocognitive disorder with Lewy bodies (brain disease that causes memory loss and movement problems), dementia in other diseases classified elsewhere unspecified severity with agitation, and anxiety disorder. The 4/10/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of zero out of 15. The resident required partial to substantial assistance with ADLs, had impaired memory and demonstrated no rejection of care or wandering behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment revealed the resident did not display physical or verbal behaviors directed towards others during the assessment look back period. 2. Record review The comprehensive care plan, initiated 8/30/24 and revised 11/21/24, documented Resident #13 had impaired cognitive functioning or impaired thought processes related to dementia and psychotropic drug use. The care plan indicated he was an elopement risk and a wanderer, related to wandering behaviors and dementia. Pertinent interventions included assessing the resident for fall risk and identifying the pattern of wandering , whether it was purposeful, aimless or escapist. Staff implemented reorientation strategies such as signs, pictures, and memory boxes, and redirected the resident with structured activities like walking, toileting, watching television or engaging in conversations. IV. Staff interviews RN #3 was interviewed on 5/13/25 at 2:25 p.m. RN #3 said Resident #12 was not physically aggressive toward other residents, but had displayed verbal aggression. She said the resident's verbal outbursts were triggered by questions related to his placement on the secure unit or his reason for being at the facility. RN #3 said typically around 2:30 p.m. the resident often became verbally aggressive toward other residents. She said during the incident with Resident #13 she was assisting another resident, which prevented her from intervening to stop the behavior. RN #2 was interviewed on 5/13/25 at 2:28 p.m. RN #2 she said she did not typically work on the secure unit, but she was aware that Resident #12 could be aggressive. Certified nurse aide (CNA) #1 was interviewed on 5/13/25 at 4:10 p.m. CNA #1 said this (5/13/25) was her first day working on the secure unit, as she had volunteered to work there and it was not her usual assignment. She said she was aware of Resident #12's behavior and said that there was nothing staff could have done to prevent the situation with Resident #13. She said the staff had done everything they could to manage the resident appropriately. The director of nursing (DON) was interviewed on 5/13/25 at 4:46 p.m. The DON said she had been working at the facility for two months. She said Resident #10 was generally pleasant. She said Resident #12 was newer to the secure unit and he could become anxious at times, but was typically redirected verbally. The DON said the incident on 3/29/25 between Resident #10 and Resident #12 occurred when Resident #10 entered Resident #12's room. She said Resident #12 did not like his personal space being disturbed. The DON said the facility implemented a stop sign on Resident #12's bedroom door after the incident and encouraged line-of-sight supervision of residents to help prevent future incidents. The social services director (SSD) was interviewed on 5/13/25 at 5:08 p.m. The SSD said Resident #12 was placed in the secure unit because he was an elopement risk. She said Resident #12 needed constant reminders and redirection. She said she was not aware of the verbal incident that occurred earlier that day (5/13/25), in which Resident #12 yelled at Resident #13, until it was brought to her attention during the interview. She said now that she was aware of the incident, she would assess the situation and would determine appropriate interventions for Resident #12 and Resident #13. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD was interviewed again on 5/13/25 at 5:56 p.m. The SSD said she had completed an evaluation with Resident #13 and he did not present with any awareness or indication of past trauma and had no recollection of the incident that occurred earlier that day with Resident #12. She said that both Resident #12 and Resident #13 were sitting together during dinner and showed no signs of agitation. She said they appeared to be getting along without any issues. The NHA was interviewed on 5/13/25 at 6:00 p.m. The NHA said Resident #12 demonstrated sundowning (evening confusion) behaviors. He said the facility completed a medication review and made adjustments to help manage his behaviors. He said Resident #12 tended to become upset when other residents entered or approached his personal space, which was why staff placed a velcro stop sign on his door to cue other residents not to enter his room. The NHA said following the verbal incident between Resident #13 and Resident #12 on 5/13/25, the facility assigned one-on-one supervision to the resident until the care planning committee could determine appropriate interventions to ensure the safety of Resident #12 and other residents.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52288 Based on record review and interviews, the facility failed to ensure that residents were free from significant medication errors for one (#1) of three residents reviewed for medication errors out of 11 sample residents. Specifically, the facility failed to ensure Resident #1 was administered antibiotic medications per physician's orders. Findings include: I. Resident #1 A. Resident status Resident #1, age 83, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included diverticulitis of intestine part unspecified with perforation and abscess without bleeding (disease that causes inflammation and infection in the intestine), abscess of intestine, lower abdominal pain unspecified and bipolar disorder (mental illness). The 5/6/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. B. Resident interview Resident #1 was interviewed on 5/12/25 at 3:28 p.m. She said the facility did not administer her prescribed antibiotic when she was admitted to the facility because they did not have her medications available. C. Resident representative interview Resident #1's representative was interviewed on 5/12/25 at 6:09 p.m. She said the resident was admitted on [DATE] at approximately 4:30 p.m. She said that the resident did not receive any of her prescribed antibiotic medication since she admitted to the facility. D. Record review Review of the May 2025 CPO revealed the following physician's order: Fidaxomicin oral tablet (antibiotic medication) 200 milligrams (mg), give one tablet by mouth two times a day for 10 days for diverticulitis, abscess of pelvis and clostridioides difficile (C-diff bacterial infection of the intestines) carrier related to abscess of intestine (a bacterial infection that causes diarrhea and inflammation of the colon), ordered 5/3/25. Review of the May 2025 medication administration record (MAR) (5/2/25 to 5/12/25) revealed Fidaxomicin oral tablet was not administered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes from 5/2/25 to 5/12/25 revealed documentation that indicated the above medication was not available and was not administered. The 5/5/25 nursing note documented that a voicemail was left with the infectious disease doctor to inquire about Fidaxomicin and possible alternatives. The medication remained on hold per the physician assistant (PA) pending clarification. -Review of Resident #1's electronic medical record (EMR) did not reveal further documentation regarding why Resident #1's antibiotic was placed on hold or the anticipated date that the medication would be delivered to the facility. III. Staff interviews Registered nurse (RN) #1 was interviewed on 5/13/25 at 10:45 a.m. She said they were not able to start the Fidaxomicin oral tablet because the medication was not in stock and the provider was notified to obtain an alternative. Certified nurse aide with medication aide authority (CNA-Med) #1 was interviewed on 5/13/25 at 11:00 a.m. She said the facility did not have Fidaxomicin oral tablet available. She said it was very expensive, approximately $5,000. She said the provider was notified. She said that their emergency kit typically included other antibiotics, Fidaxomicin oral tablet was not one of them because it was not a common antibiotic. The director of nursing (DON) was interviewed on 5/13/25 at 11:38 a.m. She said she had been working at the facility for two months. She said the pharmacy contacted her the day after the Resident #1's admission and said that Fidaxomicin was not available and might take 24 to 48 hours to obtain. She said that she then contacted the infectious disease doctor to request an alternative medication, left a voicemail, but did not receive a call back. She said the following day she called the hospital to try another route for clarification but did not document that call. She said that the PA was not too concerned about the delay and advised to place the medication on hold. She said the plan was to revise the order once they received clarification from the infectious disease doctor. She said she should have called the infectious disease doctor or primary care physician again later to clarify for how long to hold the antibiotic. The PA was interviewed on 5/13/25 at 12:22 p.m. She said that the infectious disease doctor recommended a 10-day course of Fidaxomicin due to the Resident #1's history of C. difficile and the resident's use of multiple antibiotics. She said she relayed the recommendation to the facility and emphasized the need to obtain the medication as soon as possible. She said the facility's pharmacy had difficulty obtaining the medication but said she was not aware that the resident never received it. She said there was no approved alternative to Fidaxomicin for the resident's condition and no documentation of discontinuation or substitution by the medical team. She said that while the resident did not appear to suffer immediate harm, the failure to provide the prescribed antibiotic posed a risk for recurrence or worsening of C-diff.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 52832 Based on observations and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Specifically, the facility failed to: -Repair detached and soiled hallway ceiling tiles; -Repair improperly secured light fixtures; -Maintain swamp coolers in a safe, functional, and sanitary condition; and, -Repair sagging drywall caused by inadequate attachment to the supporting framing. Findings include: I. Facility policy and procedure A request was made to the nursing home administrator (NHA) on 5/13/25 for the facility's policy for maintaining a safe and sanitary environment; however, the policy was not provided by the end of the survey (on 5/13/25). II. Observations On 5/12/25, environmental observations of the facility were conducted throughout the day, beginning at 10:21 a.m. The following was observed. A. Ceiling tiles Several ceiling tiles were detached from their mounts. Additionally, ceiling tiles revealed structural weakening and visible wear. The surfaces of the ceiling tiles were discolored in yellow and brown tones and the tile edges were frayed, jagged and uneven. The staining varied in color intensity and in patterned shapes, with some areas displaying new growth patterns and other areas marked by distinct water rings, suggesting repeated water damage. B. Drywall The drywall in the common areas, in the nurses' station areas and where the hallways converged exhibited visible discoloration, indicating potential moisture exposure. The affected areas revealed irregular staining, ranging from yellowish-brown water spots to dark patches. C. Light fixtures (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The light fixtures in the foyer area were partially detached from the ceiling, with visible gaps between the mount and the ceiling's surface. The wiring and support components of the light fixture were exposed. The light fixtures were located in a high-traffic area where residents passed beneath them. D. Swamp coolers In the 500 hallway/corridor, four swamp cooler fans were observed to be discolored and soiled with brown, yellow, or gray matter. III. Staff interviews The maintenance director (MTD) was interviewed on 5/12/25 at 11:00 a.m. The MTD said repairs of the facility environment began approximately three months ago, early in February 2025, but he said he was unable to find documentation of the facility's maintenance records. He said an external agency was contracted to perform the initial tile repairs; however, he said they were not authorized to complete the project, resulting in unfinished work. The MTD said certain sections of the drywall were not securely fastened to the framing, presenting gaps, misalignment, or loose panels. He said the drywall fasteners could be improperly spaced or insufficient, resulting in instability, and the lack of repairs could lead to premature damage, structural weakness, and noncompliance with building standards. He said corrective measures were necessary to ensure proper attachment and alignment in accordance with regulations. The MTD said the drywall repairs were necessary due to improper attachment of the walls to the supporting framing, which resulted in sagging and warping wall surfaces. He said the structural issue contributed to the ceiling tiles detaching from their mounts. The MTD said the repairs began on 4/23/25, but the contractor abruptly canceled services within 24 hours, leaving the work unfinished. The MTD said he was not sure how old the ceiling tiles in the resident hallways were; however, he said it was likely that they were quite old. He said many of the ceiling tiles needed to be replaced due to potential safety and aesthetic concerns. The MTD said there were ongoing issues with repairing the swamp coolers because the department staff lacked familiarity with the swamp coolers, including their functionality and maintenance requirements. The NHA was interviewed on 5/12/25 at 12:00 p.m. The NHA said the drywall repair work completed by the hired contractor was found to be subpar, leading to the decision to relieve them of their responsibilities on the project. He said this decision was made after multiple assessments of the quality of the work they had performed. The NHA said he and the leadership team had concerns that the ceiling tiles and the material being used during the ceiling renovation would not provide long-term durability and would create moisture issues. He said the anticipated completion date for the ongoing repairs and installation was scheduled for next week (week of 5/19/25). The NHA said he would ensure that the scheduled repairs would remain on track to finalize the project promptly, because the maintenance issues were critical and required immediate attention to restore the area to its intended condition.