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	07/08/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews, the facility failed to report alleged violations of physical abuse to the State Survey and Certification Agency in accordance with state law for two of three alleged abuse violations. Specifically, the facility failed to:-Submit a final report of the facility's investigation of a physical abuse allegation involving Resident #3 and Resident #4 to the State Agency timely; and,-Submit a final report of the facility's investigation of a physical abuse allegation involving Resident #5 and Resident #6 to the State Agency timely.Findings include:I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy dated 4/11/25 was provided by the nursing home administrator (NHA) on 7/7/25 at 2:50 p.m. The policy revealed the facility would 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 was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which could include staff to resident abuse and certain resident-to-resident altercations. Abuse also included the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It included verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.Physical Abuse included, but was not limited to hitting, slapping, punching, biting, and kicking. It also included controlling behavior through corporal punishment.The facility would have written procedures that included reporting of all alleged violations to the NHA, State Agency, adult protective services and to all other required agencies (law enforcement when applicable) within specified timeframes. The NHA would follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation, when final, within five working days of the incident, as required by the State Agency.II. Record reviewA. Physical abuse allegation on 5/6/25 at 8:15 p.m. involving Resident #3 and Resident #4The facility submitted an initial report of a physical abuse allegation to the State Agency reporting site on 5/7/25 at 8:15 p.m. The final report of the facility's investigation of the incident was due on 5/11/25.-However, the facility submitted the final report of the investigation on 5/13/25 at 7:33 a.m., which was two days after the final report was due.B. Physical abuse allegation on 5/25/25 at 1:50 p.m. involving Resident #5 and Resident #6.The facility submitted an initial report of a physical abuse allegation to the State Agency reporting site on 5/26/25 at 1:50 p.m. The final report of the facility's investigation of the incident was due on 5/30/25.-However, the facility submitted the final report of the investigation on 6/11/25 at 6:10 a.m., which was 12 days after the final report was due.III. Staff interviewThe NHA was interviewed on 7/8/25 at 11:00 a.m.The NHA agreed on the reporting dates for the physical abuse allegations, dated 5/6/25 at 8:15 p.m. and 5/25/25 at 1:50 p.m., as documented in the State Survey and Certification Agency system. The NHA said the investigations and interviews had been completed for both physical abuse allegations, however he had not submitted the final reports in a timely manner and they both were submitted late. He said he was to follow the facility's policy on Abuse, Neglect and Exploitation policy. He said this policy matched the state reporting timelines. He said he received education from regional nurse consultant (RNC) #1 on the need to follow facility policies related to the timeliness of reporting in the state portal system.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#7) of seven residents reviewed for medication management were free from significant medication errors out of nine sample residents. Resident #7 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following cerebrovascular disease (a condition that affects the blood vessels in the brain). On 6/20/25 certified nurse aide with medication authority (CNA-Med) #1 administered another resident's medications to Resident #7, including apixaban and clopidogrel (used to prevent blood clots), isosorbide (used to relax and widen the blood vessels and manage chest pain), lisinopril (used to treat high blood pressure), propranolol (used to lower heart rate and blood pressure), quetiapine (used to treat mental health conditions), Percocet (pain medication) and Fioreicet (used to treat tension headaches). The resident began to experience severe hypotension (a dangerously low blood pressure), required supplemental oxygen and was sent to the hospital. The resident received intravenous (IV) fluids, administered medications and was monitored in the intensive care unit (ICU). Specifically, the facility failed to ensure Resident #7 did not receive another resident's (Resident #8) medications. Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 7/7/25 to 7/8/25, resulting in the deficiency being cited as past noncompliance with a correction date of 6/23/25.I. Medication error on 6/20/25The facility failed to ensure a licensed nurse administered medications to the correct resident. Resident #7 was administered another resident's (Resident #8) medications, which caused the resident to experience a change in condition and the resident was sent to the hospital for treatment. II. Facility's plan of correctionThe corrective action plan the facility implemented in response to Resident #7's medication error incident on 6/20/25 was provided by the nursing home administrator (NHA) 7/7/25 at 4:02 p. m. The stated purpose of the plan was to address the significant medication error and prevent any additional residents from suffering any adverse outcome.The plan revealed the following:A. Identification of other residentsThe resident (Resident #7) who received the wrong medications was immediately transferred to the hospital.An audit of all residents was conducted to ensure a photo was present in the electronic medical record (EMR). Four residents were identified to have missing photos in their EMRs. The missing residents' photos were uploaded to their EMRs, completed 6/20/25.B. Systemic changesAll applicable facility policies and procedures were reviewed and revised.The director of nursing (DON) reeducated licensed nurses on the facility's policies regarding medication administration and medication error reporting. All nursing staff were educated prior to working their next shift, completed 6/23/25.The DON completed corrective action and one-to-one education with registered nurse (RN) #1, completed 6/21/25. All nurses and CNA-Meds received a competency observation related to medication administration prior to working their next shift, completed 6/23/25.C. MonitoringThe DON or designee would observe medication administration five times per week for four weeks, then weekly for eight weeks. Observations would occur across shifts and with various staff members.The activity director or designee would audit resident photos in the EMR weekly to ensure all newly admitted residents had photos in their chart. The NHA implemented a performance improvement plan as a means to gather and process information from the audit. Findings would be reported at the monthly quality assurance meetings for a minimum of three months.The facility's determined date of compliance was 6/23/25. III. Professional referenceAccording to [NAME], P.A., [NAME], A.G et.al,, Fundamentals of Nursing, 10th ed., Elsevier, St. Louis, Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications:1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.IV. Facility policy and procedureThe Medication Administration policy, revised 6/20/25, was provided by the NHA on 7/7/25 at 4:02 p.m. It read in pertinent part, Identify resident by photo in the MAR (medication administration record). Ensure that the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time and right documentation.V. Resident #7A. Resident statusResident #7, age less than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis following cerebrovascular disease, depression and arthritis.The 6/11/25 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview for mental status (BIMS) assessment score of 14 out of 15. The assessment documented the