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	04/30/2026

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

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interviews, the facility failed to ensure the facility had a designated designated registered nurse (RN) acting as the director of nursing (DON). Specifically, the facility utilized the DON as a floor nurse and certified nurse aide (CNA) several times when the facility's average daily census was over 60 residents. Findings include:I. Facility policy and procedureThe Nursing Services and Sufficient Staffing policy, not dated, was provided by the nursing home administrator (NHA) on 4/30/26 at 3:08 p.m. It read in pertinent part, The Director of Nursing (DON) may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. The facility is required to provide licensed nursing staff 24 hours a day, along with other nursing personnel, including but not limited to nurse aides.II. Record review The daily assignment sheets were provided by the NHA on 4/30/26 at 9:20 a.m. The daily assignment sheets showed the DON worked the following shifts: On 4/13/26 the DON worked a day shift as a charge nurse/medication nurse. On 4/16/26 the DON worked an overnight shift as a CNA.On 4/18/26 the DON worked a day shift as a CNA.On 4/19/26 the DON worked a day shift as a charge nurse/medication nurse. On 4/22/26 the DON worked a day shift as a charge nurse/medication nurse. On 4/27/26 the DON worked an overnight shift as a charge nurse/medication nurse. The facility assessment was provided by the NHA on 4/27/26 at 9:15 a.m. The facility assessment revealed the facility's current occupancy was 80 residents on 4/27/26.III. Staff interviewThe NHA was interviewed on 4/27/26 at 8:55 a.m. The NHA said the census as of midnight on 4/26/26 was 80. Licensed practical nurse (LPN) #3 was interviewed on 4/28/26 at 11:50 a.m. LPN #3 said the DON resigned mid April 2026. She said the IDON filled in on the overnight shift when there were not enough nurses. LPN #3 said the assistant director of nursing (ADON) was a LPN.The DON was interviewed on 4/29/26 at 2:30 p.m. The DON said she had accepted the DON position on 4/16/26. She said she worked an overnight shift as a CNA on 4/16/26. The DON said she worked a night shift as a registered nurse on 4/27/26, assigned to a medication cart. She said she was assigned to work on a medication cart or as a CNA when she needed to fill in, due to not having a licensed nurse or CNA to work a shift.

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interviews, record review and observations the facility failed to ensure residents consistently received food that was palatable, attractive and at an appetizing temperature.Specifically, the facility failed to ensure residents' food was palatable in temperature. Findings include:I. Facility policy and procedureThe Food Preparation Guidelines, 4/11/25, was provided by the nursing home administrator (NHA) on 4/30/26 at 3:30 p.m. It read in pertinent part, It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status. Food shall be prepared by methods that conserve nutritive value, flavor and appearance. This includes, but is not limited to: Minimizing holding time prior to meal service. Food and drinks shall be palatable, attractive and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include: Serving hot foods/drinks hot and cold foods/drinks cold and addressing resident complaints about foods/drinks.II. Resident interviewsResident #42 was interviewed on 4/27/26 at 11:00 a.m. Resident #42 said the food was a bummer. She said the food was delivered warm sometimes. She said half the time it was delivered cold.Resident #12 was interviewed on 4/27/26 at 11:30 a.m. Resident #42 said the food was delivered sometimes warm and sometimes not, about half and half. Resident #5 was interviewed on 4/27/26 at 12:44 p.m. Resident #5 said the food was not usually warm when it was delivered.Resident #7 was interviewed on 4/27/26 at 1:46 p.m. She said the food was often served cold and it made her feel aggravated.Resident #1 was interviewed on 4/27/26 at 2:45 p.m. Resident #1 said her food was not delivered warm.Resident #54 was interviewed on 4/28/26 at 9:00 a.m. Resident #54 said the food was not warm when it was delivered. He said most of the time it was cold. III. Resident group interviewFive residents (#15, #39, #51, #67, and #78) were identified as alert and oriented by facility and assessment and were interviewed on 4/28/26 at 1:00 p.m. All of the residents frequently attended the resident council meetings. Resident #15 and Resident #51 said the food was room temperature when it was delivered in the dining room. Resident #67 said the food was cold when delivered to the room. The group said they had brought this issue up at previous resident council meetings. IV. Record reviewResident council meeting notes, dated 1/6/26, documented residents reported food at breakfast and lunch was cold. The minutes documented a grievance form was completed.-The facility's response for the 1/6/26 grievance form did not address food temperatures. The February 2026 culinary council meeting minutes documented concerns about food being served cold. The facility's response was acknowledging the concern and advised the residents the staff was working on improving food temperature consistency. Resident council meeting notes, dated 2/9/26, documented prior concerns from January 2026 would be addressed in the resident council meeting scheduled for March 2026. The March 2026 culinary council meeting minutes documented concerns regarding food temperature. The NHA and dietary manager (DM) provided updates that improvements were in progress to address timely meal service. Resident council meeting notes, dated 3/3/26, documented residents reported the food was cold.-The grievance form written from the 3/3/26 resident council meeting did not address food temperatures. V. Test trayOn 4/28/26 at 11:45 a.m. the meal trays were being prepared for cart trays. The food carts were lined up, none of the food carts were plugged. On 4/28/26 at 11:47 a.m. the meal trays for the 600 hall were being prepared. The cart tray was delivered to the 600 hall at 11:55 a.m.At 11:57 a.m. the first tray was delivered to the resident's room.At 12:03 p.m. the test tray was removed from the cart after the last resident had been served their room tray. At 12:04 p.m. the test tray was immediately evaluated by three surveyors.The test tray consisted of honey glazed pork loin, herb stuffing, steamed carrots,and red velvet bar for dessert. Each item was placed all on one plate and covered. The red velvet bar was in a separate cup.-The stuffing registered a temperature of 118.7 degrees F.-The steamed carrots registered a temperature of 115.6 degrees F.-The red velvet bar registered a temperature of 82.6 degrees F.VI. Staff interviewsThe DM was interviewed on 4/28/26 at 11:11 a.m. The DM said he was aware of the (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	concerns regarding cold food. He said he checked the temperatures before service began and when the service was completed. The DM said he continued to work with the dietary staff on being more efficient with plating the meals and getting the meals in the cart. The DM said the carts were delivered to the halls and the certified nurse aides (CNA) were responsible for disturbing the trays. The DM said the meals should be passed out as soon as the carts were on the unit. The NHA was interviewed on 4/30/26 at 9:00 a.m. The NHA said he had not heard the resident had complained of cold food. The NHA said the facility used a name brand insulated top and bottom combination for room trays. He said the facility also incorporated a plate warmer to raise the temperature of the plates prior to the plating of the residents' food. The NHA said the facility transported the foods to resident rooms with an enclosed metal tray-serving cart, which was plugged into an electrical outlet while it was in the kitchen. The NHA said this would help keep the food warm during room tray preparation. The NHA said the staff did not plug the cart into an electrical outlet once it left the kitchen.-However, during kitchen observation on 4/27/26 and 4/28/26 the one metal tray-serving cart, which could be plugged in, was not plugged while it was in the kitchen (see observations above).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the two of two nourishment refrigerators.Specifically, the facility to ensure safe and appropriate food storage of food items in the nourishment refrigerators. Findings include:I. Professional referenceThe Colorado Retail Food Regulations, (3/16/24) and retrieved on 5/5/26 read in pertinent part, Commercially processed food: open and hold cold, refrigerated, ready-to-eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, the day the original container is opened in the food establishment shall be counted as day one and the day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under. (3-501.17)The [NAME] Uncrustable Sandwiches Website Frequently Asked Questions, retrieved from https://www.smuckersuncrustables.com/frequently-asked-questions We suggest keeping our products frozen until ready to thaw. Thaw for 30 to 60 minutes at room temperature for the best results and consume within 8 to 10 hours. We do not recommend microwaving these sandwiches as the filling can become very hot and pose a safety hazard. Uncrustables(R) sandwiches should not be thawed and refrozen. Once thawed, Uncrustables(R) sandwiches may be refrigerated for up to 24 hours. However, refrigerating may dry out the bread. For best flavor and experience, we recommend eating within 8 to 10 hours of thawing. II. Facility policy and procedureUse of Storage of Food Brought in by Family or Visitors policy, dated 4/11/25, was provided by the nursing home administrator (NHA) on 4/27/26 at 5:23 p.m. It read in pertinent part, It is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator; the prepared food must be consumed by the resident within three days; if not consumed within three days, and food will be thrown away by facility staff. All items not maintained are subjected to being thrown away if not removed by the resident and/or resident representative.The Kitchen Sanitation policy, dated 12/22/25, was provided by the NHA on 4/30/25 at 3:30 p.m. It read in pertinent part: It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. The sanitation program will provide inspections to be conducted of the food service areas. Sanitation inspections will be conducted in the following manner:Daily: Food service staff shall inspect refrigerators/coolers, freezers, storage area temperatures and dishwasher temperatures daily. Weekly: The dietary manager shall inspect all food service areas weekly to ensure the areas are clean and comply with sanitation and food service regulation. Inspections will be conducted but not limited to the following areas: dry storage, freezer, refrigerator, dish room, pot wash, main production area, food preparation area, general dietary observations.III. ObservationsOn 4/28/26 at 4:15 p.m. the following was observed in the 300 hall nourishment refrigerator and freezer:-There was a plastic pitcher that contained red colored liquid which was not labeled or dated. -There was a plastic pitcher that contained yellow colored liquid which was not labeled or dated. -There was a plastic pitcher that (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	contained white colored liquid that was not labeled or dated. -There were five thawed Uncrustables sandwiches in the refrigerator not dated.On 4/28/26 at 4:28 p.m. the following was observed in the 600 hall nourishment refrigerator:-There were two juice bottles, with the same resident name, one bottle expired 1/26/26 and the other bottle expired 2/10/26. -There was a plastic container of grapes with no name or date. The grapes had wrinkled skin with brown stems and there was brown fluid in the plastic container.-There was a bottle of chocolate milk with a resident's name and an expiration date of 4/26/26. The chocolate milk appeared to contain brown chunks in the bottle.-There were seven Uncrustable sandwiches, not dated. -A resident's pizza box dated 4/8/26. -A resident's pizza box dated 3/29/26.-A resident's pizza box dated 4/20/26. -A resident's pizza box dated 4/21/26.On 4/30/26 at 1:50 p.m. the following was observed in the 300 hall nourishment refrigerator:-A resident's personal food containing store bought sliced meat that had a film covering over the meat and dripping fluid coming out of the container, was not dated.-Five thawed Uncrustable sandwiches with no date.-Two juice pitchers with no label or date. -Nineteen health shakes with no pull dates. On 4/30/26 at 2:00 p.m. the following was observed in the 600 hall nourishment refrigerator:-Four thawed Uncrustable sandwiches with no dates.-Four residents' pizza boxes.-Three thawed health shakes with no pull date. IV. Staff interviewsLicensed practical nurse (LPN) #3 was interviewed on 4/28/26 at 4:28 p.m. She said the night shift was supposed to clean out the nourishment refrigerator/freezer. The NHA was interviewed on 4/30/26 at 10:12 a.m. The NHA said the certified nurse aides (CNA) should be cleaning out the nutrition refrigerators as needed. The NHA said all items in the refrigerators and freezers should be labeled and dated and expired food should be cleaned out. The dietary manager (DM) was interviewed on 4/30/26 at 2:10 p.m. The DM said he was not sure who should be cleaning out the nourishment refrigerators. He said the dietary staff were responsible for taking the drinks and snacks to the units. He said it would be important to clean out the refrigerators so residents were not served expired foods or drinks. The DM said all items in the refrigerators and freezers needed to be labeled and dated. He said the Uncrustables sandwiches should not be in the refrigerators longer than three days.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to employ an infection preventionist (IP) who had completed specialized training in infection prevention and control which had the potential to affect all residents residing in the facility at the time of the survey. Specifically, the facility failed to employ an infection preventionist (IP) with specialized training in infection prevention and control. Findings include:I. Record reviewThe facility provided a certificate of infection prevention training with an expiration date of 2024 for the current IP.II. Staff interviewsThe IP was interviewed on [DATE] at 3:00 p.m. The IP said she was the assistant director of nursing (ADON). She said she was combining responsibilities of the ADON and the IP. She said she did not realize her certification had expired. She said she started doing the training online, but was not able to complete the training to receive her certification. The chief nursing officer was interviewed on [DATE] at 5:00 p.m. She said she did not realizethat the IP was not certified. She said she did not have an infection prevention certification. The chief nursing officer said the IP needed to complete her training and certification.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure that its medication error rate was not greater than five percent (%).Specifically, the facility had a medication error rate of 44%, which was 11 errors out of 25 total opportunities for error. Findings include:I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed., E.[NAME], St. Louis Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environmentˆ.ˆ ˆˆProfessional Standards such as nursing scope ˆand standards of practice apply to the activity of medication administrationˆ. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. ˆMany medication errors ˆcan be linked ˆin some way to an inconsistency ˆin adhering to these seven rightsˆ: 1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.II. Facility policy and procedureThe Medication Administration policy, revised on [DATE], was provided by the chief nursing officer on [DATE] at 6:42 p.m. Compare the medication source (bubble pack, vial) with the medication administration record (MAR) to verify the resident's name and medication name. Review MAR to identify medication to be administered. Administer within 60 minutes before or after the scheduled time unless otherwise ordered by the physician. Identify expiration date. If expired, notify nurse manager. Sign MAR after administration. For those medications requiring vital signs, record vital signs on the MAR. Ensure that the six rights of medication administration are followed:a. Right residentb. Right drugc. Right dosaged. Right routee. Right timef. Right documentation Insulin and Diabetes Agents: Must be timed precisely around meals to manage glucose levels effectively.II. Observations and record reviewA. Resident #93On [DATE] at 11:32 a.m. registered nurse (RN) #2 prepared and administered 40 units of Lantus and 12 units of insulin lispro to Resident #93.The physician's orders read:Lantus Subcutaneous Solution 40 unit/milliliter (ml) (Insulin Glargine) Inject 40 units subcutaneously two times a day for Type 1 Diabetes Mellitus. The order was scheduled to be administered at 7:00 a.m. to 9:00 a.m.-Lantus was administered at 11:32 a.m., which was two hours and 31 minutes after the medication administrator window. RN #2 did not prime insulin pen prior to administering the insulin. Insulin Lispro Injection Solution 12 unit/ml (Insulin Lispro). Inject 12 units subcutaneously three times a day for Type 1 diabetes mellitus. Give before meals. The order was scheduled to be administered at 7:00 a.m. to 9:00 a.m.-RN #2 administered insulin Lispro at 11:32 a.m., which was two hours and 31 minutes after the medication administrator window. RN #2 did not prime insulin pen prior to administering the insulin. B. Resident #6On [DATE] at 9:09 a.m. the assistant director of nursing (ADON) prepared and administered two 500 mg tables of acetaminophen to Resident #6. The physician's orders read:Acetaminophen oral packet 500 milligrams (mg). Give 1000 mg by mouth three times a day for pain. The order was scheduled to be administered at 7:00 a.m., 2:00 p.m. and 9:00 p.m. -The ADON administered the acetaminophen in the wrong form and one hour outside the allowed medication administration window. C. Resident #68On [DATE] at 10:15 a.m. the ADON prepared and administered the following medications to Resident #68:Farxiga oral (medication used to treat diabetes) tablet 10 mg;Metoprolol Succinate (to treat high blood pressure) oral capsule 25 mg extended release (ER) 24 hour; Lisinopril oral tablet (to treat high blood pressure) 10 mg; and,Oxycodone HCl oral tablet (pain medication) 5 mg.Review of Resident #68's [DATE] computerized physician's orders (CPO) revealed the resident's physician's order: Farxiga oral tablet 10 mg. Give 10 mg by mouth one time a day at 7 a.m. to 9 a.m. Hold if glucose was less than 70 milligrams per deciliter (mg/dl).-However, the ADON administered the medication one hour and 15 minutes outside the allowed medication administration window, and she did not check the resident's blood sugar to ensure it was above 70 mg/dl. Metoprolol Succinate Oral Capsule ER 24 Hour Sprinkle 25 mg. Give one capsule by mouth in the morning for (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hypertension. The medication was scheduled to be administered from 7:00 a.m. to 9:00 a.m.Lisinopril oral tablet 10 mg. Give one tablet by mouth in the morning for hypertension. The medication was scheduled to be administered from 7:00 a.m. to 9:00 a.mOxycodone HCl oral tablet 5 mg. Give one tablet by mouth every morning and at bedtime for pain The medication was scheduled to be administered from 7:00 a.m. to 9:00 a.m. -However, the ADON administered the medication one hour and 15 minutes outside the allowed medication administration window. D. Resident #73On [DATE] at 10:03 a.m. RN #4 prepared and administered the following medications to Resident #73Amlodipine Besylate oral tablet (to treat high blood pressure) 10 mg.Review of Resident #73's [DATE] CPO revealed the resident's physician's order: Amlodipine Besylate oral tablet 10 mg. Give 10 mg by mouth one time a day for hypertension. The medication was scheduled to be administered from 7:00 a.m. to 9:00 a.m.-However, RN #4 administered the medication one hour outside the allowed medication administration window. E. Resident #8On [DATE] at 10:57 a.m. RN #4 prepared and administered the following medications to Resident #8:Insulin Glargine Solution 50 units;Humalog KwikPen Subcutaneous Solution Pen-injector 6 units; and, Sertraline HCl oral tablet 100 mg Review of Resident #8's [DATE] CPO revealed the resident's physician's order: Insulin Glargine Solution 55 units subcutaneous. The medication was scheduled to be administered from 7:00 a.m. to 9:00 a.m.-However, RN #4 administered the medication one hour and 57 minutes outside the allowed medication administration window and administered 50 units instead of 55 units per physician's orders.HumaLOG KwikPen Subcutaneous Solution per sliding scale to be administered from 7 a.m. to 9 a.m. -However, RN #4 administered the medication one hour and 57 minutes outside the allowed medication administration window.Sertraline HCl Oral Tablet 25 MG (Sertraline HCl). Give 25 mg. This medication was scheduled to be administered from 7:00 a.m. to 9:00 a.m.-However, RN #4 administered 75 mg above the physician's order and administered the medication one hour and 57 minutes outside the allowed medication administration window. III. Staff interviewsRN #2 was interviewed on [DATE] at 11:35 a.m. RN#2 said she would notify the physician of the late administration of insulin. RN #2 said she forgot to prime the insulin pen prior to administering. The ADON was interviewed on [DATE] at 10:50 a.m. The ADON said she was not familiar with the medication cart, and that was why she was administering medications late. She said she would notify the physician once she had a complete list of residents with late medications. The ADON said she did not realize that Resident #68 needed a blood glucose check.RN #4 was interviewed on [DATE] at 2:49 p.m. RN#4 said he was behind giving medications because he was assisting with dental appointments. RN #4 He did not realize he was five units short when he prepared to administer the insulin. He said he administered Sertraline 100 mg, because that was the dose in the bubble pack from the pharmacy. He said the physician's order indicated to administer 25 mg instead of 100 mg. RN #4 said he should have been looking at the MAR more closely and had fewer distractions.The chief nursing officer was interviewed on [DATE] at 3:00 p.m. She said she had done education in the morning hours with the nursing staff for medication administration. The chief nursing officer was aware that the nursing staff were struggling to give residents their medications on time. She said she would be educating the nursing staff again on the importance of the six rights of medication administration. The chief nursing officer said Sertraline was administered correctly. She said the order recently was reduced from 125 mg to 100 mg. The order was transcribed inappropriately and the order for 100 mg was discontinued in error, leaving an active order for 25 mg. She said MAR was immediately corrected to ensure the resident was receiving the appropriate dose.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure that all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards for two of three medication carts. Specifically, the facility failed to: -Ensure inhaler medications and ophthalmic solution were marked with the date when the medications were opened;-Ensure insulin was labeled with the date they were opened;-Ensure there were no loose pills in the medication cart; and,-Ensure that expired medications were disposed of properly. Findings include:I. Professional referenceAccording to the manufacturer recommendations Latanoprost 0.005% ophthalmic solution prescribing information read in pertinent parts, Once opened, manufacturers recommend discarding eye drops after 28 days. Latanoprost 0.005% eye drops must be discarded four to six weeks after opening, regardless of the expiration date on the bottle. According to the Spiriva Respimat (tiotropium bromide) inhaler package insert, retrieved on 5/5/26 from https://pro.boehringer-ingelheim.com/us/bipdf/spiriva-respimat-us-pi After assembly, the Spiriva Respimat inhaler should be discarded, at the latest, three months after first use or when the locking mechanism is engaged, whichever comes first.The Food and Drug Administration (FDA) Insulin Storage and Effectiveness (revised 9/19/17), was retrieved on 5/6/26 from fda.gov/drugs/emergency-preparedness-drugs/information-regarding-insulin-storage-and-switching-between-p It read in pertinent part, Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59 (degrees) Fahrenheit (F) and 86 F for up to 28 days and continue to work.The United States Food and Drug Administration (USDA) Don't Be Tempted to Use ExpiredMedicines (revised 10/31/24), was retrieved on 5/6/26 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth, and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed, there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it.II. Facility policy and procedureThe Medication Storage policy, not dated, was provided by the chief nursing officer on 4/29/26 at 6:42 p.m. It read in pertinent part, It is the policy of this facility to ensure all medications housed on our premises will be stored to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. All drugs and biologicals will be stored in locked compartments. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Any discrepancies that cannot be resolved must be reported immediately as follows: Notify the director of nursing (DON), charge nurse, or designee, and the pharmacy. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, illegible, or missing labels.III. ObservationsOn 4/27/26 at 9:18 a.m. the medication cart was observed with registered nurse (RN) #2 on hallway 300 and 700. The following medications were found:-Olopatadine Hydrochloride ophthalmic solution 0.2% was not labeled when it was opened.-Latanoprost ophthalmic solution was not labeled when it was opened.-Latanoprost 0.005% was not labeled when it was opened.-Symbicort 160/45 inhaler was not labeled when it was opened.-Ventolin HFA (albuterol inhaler) 90 micrograms was not labeled when it was opened.-Fluticasone propionate (Flovent inhaler)was not labeled when it was opened.-Spiriva inhaler was not labeled when it was opened.-Forty four loose unidentified medications were found in the medication cart.On 4/27/26 at 9:45 a.m. observation of the medication cart for the hallway 100 and 400 with licensed practical nurse (continued on next page)

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	04/30/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(LPN) #2 The following medications were found:-Prednisone (steroid) 20 mg pack that expired on 3/25/26-Prednisone 20 mg pack that expired on 4/7/26.-Six medications were found loose at the bottom of the drawer in the medication cart. IV. Staff interviewsRN #2 was interviewed on 4/27/26 at 9:40 a.m. RN #2 said she was not sure who was responsible for cleaning out the medication carts and she would to ask the assistant director of nursing (ADON). LPN #2 was interviewed on 4/27/26 at 9:55 a.m. LPN #2 said the night nurse was responsible for cleaning the medication cart. LPN #2 said she did not know who completed the monthly chart audits of medication cart cleaning. The chief nursing officer was interviewed on 4/27/26 at 10:10 a.m. She said each nurse was responsible for cleaning and maintaining the medication cart. She said the cart should be cleaned during their shift. She said if the nurse dropped a medication in the drawer, they should pick it up and dispose of it correctlyThe director of nursing (DON) was interviewed on 4/29/26 at 2:30 p.m. The IDON said the medication carts were cleaned by everybody working on that medication cart. The IDON said the night shift should also be cleaning them at night. She said the pharmacy completed medication cart audits. The DON said all medication should be labeled and dated when opened.

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on record review and interviews the facility failed to ensure meals were served according to the resident's preferences on three of four units. Specifically, the facility failed to provide menus to residents in order for the residents to choose their meals and honor food preferences. Findings include:I. Facility policy and procedureThe Food Preparation Guidelines policy and procedure, dated 4/11/25, was provided by the nursing home administrator (NHA) on 4/30/26 at 3:30 p.m. It read in pertinent part: Food and drinks shall be palatable, attractive and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include: Honoring resident preferences, as possible, regarding foods and drinks. Staff shall accommodate resident allergies, intolerances, and preferences, providing appropriate alternatives when needed.II. Resident interviewsResident #5 was interviewed on 4/27/26 at 12:44 p.m. Resident #5 said she was not offered menus at night. She said a few times since her admission the night certified nurse aides (CNA) took her meal order for the next day, which was nice so she knew what she was going to have for her meals. Resident #5 said if she did not fill out the meal ticket she would not know what she was going to be served, because they just provided the main option. Resident #5 said she preferred to choose her own meals, so she could order what she liked. She said she did not always eat the full meal because it was not something she would have ordered for herself and would like the opportunity to order different items. She said she was aware of the alternate menu and would choose items off of that menu. She said she did not ask for anything different when her meal was passed because she would rather try to eat what was served than have to wait for anything else. Resident #1 was interviewed on 4/27/26 at 2:45 p.m. Resident #1 said the menus were not available the night before so she would not know what she would receive until the meal was served. She said she was not happy about that and would like to be able to choose her own meals. She said it takes too long to wait for an additional meal if she requested another meal. Resident #42 was interviewed on 4/27/26 at 3:22 p.m. Resident #42 said the food was a bummer for her, because she did not choose her meals daily. She said the CNAs used to pass out and assist with the menu selection the night before, but that was not happening very often anymore. Resident #42 said when she did not fill out her menu she was served the main meal for the day and would not know what that was until she received it. Resident #42 said who knew what you would get, and said she would prefer to choose her meals. Resident #42 said it was frustrating not choosing her meal. Resident #54 was interviewed on 4/28/26 at 10:00 a.m. Resident #54 said he was not getting the option to choose his meals and got what he got. He said he was served the main meal, which was not always what he would choose for himself so he just would not eat it. He said if asked for something else it would take too long so he would wait until the next meal and maybe have a snack. Resident #54 said he was not provided the menu options the night before like he used to be. III. Resident group interviewFive residents (#15, #39, #51, #67, and #78) were identified as alert and oriented by facility and assessment and were interviewed on 4/28/26 at 1:00 p.m. All of the residents frequently attended the resident council meetings. Resident #15 and Resident #51 said the CNAs were not consistently getting the menu tickets filled out for the following day. Residents#15 and Resident #51 said they did not always know what they were going to be served the next day, because they did not choose their meals. Resident #51 said the CNAs used to take the orders the night before, but that was not happening all the time. Residents #15 and Resident #51 said it was upsetting not being able to order what they wanted.IV. Record reviewResident council meeting minutes, dated 1/6/26, revealed the residents in attendance had concerns that the dietary staff were not reading the meal tickets. The facility did not have a response documented on the resident council minutes. Resident council meeting minutes, dated 3/3/26, revealed the residents in attendance continued to voice concerns about kitchen staff were not reading the meal tickets. The facility's response was that the dietary manager (DM) would re-educate the staff. Resident council meeting minutes, dated 4/7/26, revealed (continued on next page)

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	065221	A. Building B. Wing	04/30/2026

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the residents in attendance continued to voice concerns about the kitchen staff not reading the meal tickets. The facility's response was that the DM would re-educate his staff. V. Staff interviewsThe DM was interviewed on 4/28/26 at 11:11 a.m. The DM said the menus were to be completed the night before by the CNAs. The DM said the CNAs were to take the menu to the rooms, review the menus and alternates and fill out the meal ticket. The DM said the CNAs were to return the meal tickets by 5:30 a.m. the next morning. The DM said he was not sure if the tickets were completed with the residents or filled out by staff.CNA #4 was interviewed on 4/29/26 at 6:06 p.m. CNA #4 said it was the CNAs' responsibility to go room to room with the menus and assist, if needed, residents to fill out their menu ticket for the next day. She said if she was unable to get the task done the morning shift would fill out the menu tickets. CNA #3 was interviewed on 4/29/26 at 6:18 p.m. CNA #3 said the CNAs' received the menu tickets for each hall. CNA #3 said the CNAs went over the menu and alternate menu with the resident, then filled out the ticket with the residents. CNA #3 said the tickets were returned to the kitchen for the next day's meal. CNA #3 said it had happened only a few times that she was unable to complete tickets because it was a busy shift.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to honor resident choices for two (#5 and #54) of 18 residents reviewed out of 40 sample residents. Specifically, the facility failed to ensure Resident #5 and Resident #54 received showers consistently according to the residents' preferences and plan of care. Findings include:I. Facility policy and procedureThe Resident Showers policy, dated 12/4/25, was provided by the nursing home administrator (NHA) on 4/30/26 at 3:30 p.m. It read in pertinent part, It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards or practice. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident preferences and safety.II. Resident #5A. Resident statusResident #5, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included lymphedema, morbid obesity with alveolar hypoventilation (slow breathing), and muscle weakness.The 4/13/26 minim data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent on staff for lower body dressing and required maximal assistance with upper body dressing. She was partial to moderate assistance with showers. Resident #5 was dependent for mobility.The MDS documented the resident did not refuse care.B. Resident interviewResident #5 was interviewed on 4/27/26 at 12:44 p.m. Resident #5 said she wanted one shower a week. She said since she was admitted on [DATE] she had one shower, which was on 4/26/26. She said she was not asked about getting a shower and went two and half weeks without a shower. She said she felt dirty and her hair felt greasy. C. Record reviewThe activities of daily living (ADL) care plan, initiated 4/19/26 and revised 4/23/26, revealed the resident had a risk for decline in ADL function related to activity intolerance, respiratory disease, and morbid obesity. Pertinent interventions included, Resident #5 required assistance with bathing.Resident #5's point of care (POC) response history for the bathing task revealed Resident #5 preferred shower day was Sunday during the day shift after lunch. Review of Resident #5's POC response history for the bathing task from 4/8/26 to 4/26/26 revealed the resident had one shower on 4/26/26. III. Resident #54A. Resident status Resident #54, age less than 65, was admitted on [DATE]. According to the April 2026 CPO diagnoses included paraplegia, pressure ulcer right buttock, stage 4, left buttock pressure ulcer, stage 4, neurogenic bowel, neurogenic bladder, infection and inflammatory reaction due to other urinary catheter, initial encounter and other chronic osteomyelitis left thigh.The MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. Resident #54 required touching assistance to setup or clean-up assistance with ADLs. B. Resident interviewResident #54 was interviewed on 4/28/26 at 10:00 a.m. Resident #54 said he had refused a couple of showers because of not feeling well or he had pain. He said his preference was to shower three times a week during the day shift, but he was not asked three times a week. Resident #54 said if he declined, he was not offered a bed bath, a shower at a different time or a different day. He said he went many days without a shower. C. Record reviewThe ADL care plan, initiated 11/22/24 and revised 11/28/24, revealed the resident had an ADL self-care performance deficit related to activity intolerance, weakness and paraplegia. Pertinent interventions included encouraging the resident to discuss feelings about self-care deficit, encouraging the resident to participate to the fullest extent possible with each interaction, and monitoring/documenting/reporting as needed any changes, any potential for improvement, reasons for self care deficit, expected course, declines in function. Resident #54's POC response history for the bathing task revealed Resident #54 preferred showers on Monday, Wednesday and Friday during the day shift. Review of Resident #54's POC response history for the bathing task from 3/30/26 to 4/24/26 documented the resident received one shower out of nine opportunities. The documentation (continued on next page)

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	065221	A. Building B. Wing	04/30/2026

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the POC response history for the bathing task revealed the following:The POC documentation revealed the staff documented on 3/30/26 that the resident was not scheduled for a bath that shift. -However, 3/30/26 was a Monday which was one of Resident #54's preferred days. The POC documentation revealed on 4/1/26 Resident #54 refused a shower.-However, the progress note dated 4/1/26 at 4:04 p.m. had no reason for the refusal or that a shower was offered at a different time. The 4/3/26 progress note documented at 5:32 p.m. revealed the resident agreed to a shower. The note documented the resident continued to delay the shower during the day and then left the building and not return until after the certified nurse aide's (CNA) shift ended. The POC documentation revealed on 4/20/26 the resident had a shower.The POC documentation revealed on 4/22/26 the resident refused a shower. -However, there was no further documentation for the reason for the refusal or that the resident was offered a shower at a different time.The POC documentation revealed on 4/24/26 the resident was not available-There was no documentation from 4/3/26 to 4/8/26, regarding the resident's showers and from 4/27/26 to 4/28/26. The resident was in the hospital from [DATE] to 4/18/26. IV. Staff interviewsCNA #2 was interviewed on 4/29/26 at 3:20 p.m. CNA #2 said there was a bath aide scheduled and the bath aide provides the showers. If there was not a bath aide available then the CNAs were responsible for completing the scheduled showers for that day. CNA #2 said the CNAs were to document when a shower was given and to notify the nurse when a resident refused to have a shower. The assistant director of nursing (ADON) was interviewed on 4/29/26 at 2:25 p.m. The ADON said if a bath aide was not scheduled then the CNAs were responsible for completing the showers for their residents. She said a bath aide was not always scheduled and sometimes the bath aide was pulled to the floor to work a shift. The ADON said the CNAs were responsible for documenting when the showers were completed. The ADON said the facility did not have an issue with completing showers for the residents.

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	065221	A. Building B. Wing	04/30/2026

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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** Based on record review and interviews, the facility failed to ensure one (#15) of 18 residents reviewed for abuse were kept free from abuse and neglect out of 40 sample residents.Specifically, the facility failed to protect Resident #15 from physical abuse by Resident #10. Findings include:I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy, implemented 4/11/25, was provided by the nursing home administrator (NHA) on 4/28/26 at 1:10 p.m. The policy revealed, the facility provided protections for the health, welfare and rights of each resident by developing/implementing written policies/procedures that prohibited/prevented abuse, neglect, exploitation and misappropriation of resident property. Abuse was defined by 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 were necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, caused 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 make efforts to ensure all residents were protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples included, but were not limited to, responding immediately to protect the alleged victim and integrity of the investigation and examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. The facility would increase supervision of the alleged victim and residents and offer room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. The facility would provide protection from retaliation and provide emotional support and counseling to the resident during and after the investigation, as needed. The facility would revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences changed as a result of an incident of abuse.II. Incident of physical abuse by Resident #10 towards Resident #15 on 3/19/26 A. Facility investigationThe 3/19/26 facility investigation, documented at 7:46 p.m., revealed Resident #15 was observed on the floor in the dining room. Resident #15 reported that Resident #10 hit him and then pushed him out of his wheelchair. Resident #15 was assessed by a nurse and assisted back into his wheelchair. The investigation documented the incident was not witnessed by staff, but there were other residents present in the dining room at the time of the incident. The investigation documented the other residents were interviewed and said Resident #10 was upset about a paper that had information about $400.00 dollars on it. The residents collectively said Resident #10 came up behind Resident #15 and hit him on the right side of the face. Resident #10 then proceeded to tip Resident #15's wheelchair over. The investigation documented a nurse assessed Resident #15 and observed a small red mark above his eyebrow. Resident #15 denied any pain. Resident #15 said that Resident #10 came up from behind him and said he took his paper. Resident #15 said Resident #10 swung at him from behind and above his right eye. The investigation documented Resident #10 was interviewed and said Resident #15 took a paper from him and this made him mad. Resident #10 said that Resident #15 told him that he did not know anything about the paper. Resident #10 said Resident #15 tried to back his wheelchair into him. Resident #10 said he grabbed Resident #15's wheelchair and dumped him out. Resident #10 said that he did not hit Resident #15. The conclusion of the investigation revealed that based on resident reports and witness statements, Resident #10 made physical contact with Resident #15, which resulted in Resident #15 being on the floor.B. Resident #15 (victim)1. Resident statusResident #15, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included cerebral infarction without residual deficits, chronic kidney disease stage 3, major depression disorder and lack of coordination.According to the 3/19/26 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15.The resident utilized a wheelchair for ambulation. The resident required substantial/maximal assistance from staff for toileting, upper body dressing, lower body dressing and personal hygiene.2. Resident interviewResident #15 was interviewed on 4/30/26 at 1:50 p.m. Resident #15 said he was in the dining room at his usual spot (on 3/19/26). Resident #15 said Resident #10 came up to him and punched in the right side of face, pulled him out of his high-backed wheelchair and he fell to the floor. Resident #15 said he did not hit Resident #10 back. He said Resident #10 accused him of stealing some paper. Resident #15 said he did not know what paper Resident #10 was talking about. Resident #15 said he was not afraid of Resident #10. Resident #15 said this was the first altercation with Resident #10. Resident #15 said he had no pain after being hit in the face and he did not have to go to the hospital. 3. Record reviewA nurse note, dated 3/19/26 at 7:45 p.m., revealed Resident #15 was found lying on the floor on his left side. The resident was oriented to person, place, time and situation. The resident had a small red bump above his right eyebrow and the skin was intact. The resident was able to move all of his extremities. The resident had no complaints of pain or discomfort. Resident #15 said that Resident #10 hit him and he (Resident #10) hit like a girl. Resident #15 was assessed and vital signs were obtained with no obvious injuries observed. A Hoyer (mechanical lift) was used to lift the resident off the floor and back into his wheelchair.An event note, dated 3/23/26 at 9:54 a.m., revealed the event occurred on 3/19/26 at 7:45 p.m. Resident #15 was found lying on the floor on his left side. The resident was alert and oriented times three. The resident had a small red bump above the right eyebrow. The resident's skin was intact with no noted reddened areas. The resident was able to move all extremities well. The resident had no complaints of pain or discomfort. The root cause identification was Resident #15 had cognitive decline at baseline, was wheelchair bound, had lack of coordination at baseline. Resident #10 was the aggressor and felt that his items (candy wrappers in the trash) had been taken by Resident #15 and he retaliated. The note documented preventative measures included psychosocial support by nursing and social services. Staff were to watch for signs and symptoms of delayed injury and neurological assessments. Staff were to separate Resident #15 from Resident #10 at all times. Staff were to ensure close supervision in common areas as indicated. Staff were to assess for fear, anxiety, withdrawal, or behavioral changes following the incident. Resident #15's care plan for being the victim of a resident-to resident altercation, including being struck in the face, tipped in a wheelchair, placing resident at risk for injury, fear, and psychosocial distress was initiated on 3/23/26. The interventions included assessing the resident for fear, anxiety, withdrawal, or behavioral changes following the incident and providing reassurance and emotional support, ensuring the resident was not left in high-risk areas unattended if vulnerability was identified, and separating Resident #15 from Resident #10 at all times and ensuring close supervision in common areas as indicated.Resident #15's Kardex (an electronic quick-reference tool that provided a concise summary of essential resident information, care plans and medical orders), printed on 4/30/26 at approximately 3:00 p.m., revealed staff were to ensure the resident was not left in high-risk areas unattended if vulnerability was identified. Staff were to separate Resident #15 from Resident #10 at all times and ensure close supervision in common areas as indicated.C. Resident #10 (assailant)1. Resident statusResident #10, age less than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included diabetes mellitus type 2, personal history of traumatic brain injury, cognitive communication deficit, dementia, disorientation and adjustment disorder with mixed anxiety and depressed moods.According to the 3/20/26 MDS assessment, the resident was severely cognitively impaired with a BIMS score of six out of 15. The resident had inattention continuously present and did not fluctuate. The resident also had disorganized thinking continuously present and did not fluctuate. The resident had no physical or (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbal behavioral symptoms directed toward others. The resident had no impairments in functional limitation in range of motion for either the upper or the lower extremities. The resident required partial/moderate assistance from staff for toileting, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene.2. Resident interviewResident #10 was interviewed on 4/30/26 at 10:22 a.m. Resident #10 said he did not remember any altercation with Resident #15. Resident #10 said he was not afraid of any residents or staff. Resident #10 said sometimes he was looking for a fight. He said this occurred when he became anxious. Resident #10 said he did not like it when people talked a lot. He said if the other people were happy, he could walk away from the incident. He said he was not afraid of Resident #15.3. Record reviewThe event note, dated 3/23/26 at 9:38 a.m., revealed an altercation occurred on 3/19/26 at 7:45 p.m. Resident #10 was observed in a physical altercation with Resident #15. Resident #10 hit Resident #15 and knocked him to the floor. Resident #10 was very angry and tried to exit-seek out the front door. Resident #10 sat in a chair in the front foyer of the facility. The risk factors and root cause identification were Resident #10 was at baseline confusion and recently had increased psychosis with a history of dementia. The preventative measures in place prior to the incident were to minimize the risk of agitation, refer to psychological counseling, staff were to interact in an empathetic/supporting manner and document behavioral events. New interventions were for Resident #10 to be placed on one-to-one caregiver supervision for safety. Staff were to monitor for signs of agitation, provide personal space during periods of agitation and redirect the resident away from peers when signs of escalation were noted. Staff were to administer medications as ordered and monitor for effectiveness and adverse side effects.A behavior care plan was initiated on 3/19/26 related to Resident #10's behaviors (paranoid thoughts, aggression, irritability often triggered by minor annoyances). The care plan documented the resident had sudden outbursts, low frustration tolerance and verbal or physical aggression. The resident had disinhibition (lack of restraint or poor self-regulation, where an individual acts impulsively without considering consequences or social norms) or a lack of filtering (cognitive distortion where an individual focuses exclusively on negative details of a situation while ignoring the positive aspects) which leads to socially inappropriate behavior. The resident had impulsivity (tendency to act swiftly on a whim without forethought, planning or consideration of negative consequences) with poor decision-making and taking risks without thinking of the consequences. The resident had egocentricity (state of being self-centered, focusing solely on one's own needs, perspectives, and interests while ignoring or failing to understand the viewpoints of others). The resident had a self-centered attitude, showing lack of empathy (ability to understand and share the feelings, thoughts, and perspectives of another person from their frame of reference, rather than one's own) or awareness of how their actions affected others. The resident had memory impairment leading to making false allegations against others and misplacing items. The interventions included assessing the resident for triggers and patterns related to accusations such as misplacement of items, time of day and staff interactions. Staff were to assist the resident with locating missing items promptly to reduce distress and reinforce trust. The staff would ensure the resident remained safe and demonstrated reduced episodes of agitation/aggression toward others through the review period. Staff would monitor the resident for signs of agitation, aggression, irritability, pacing, yelling, threatening behavior, or other escalation each shift and as needed. Staff were to redirect the resident away from peers/situations when signs of escalation were noted. Staff were to provide personal space and decrease environmental stimuli during periods of agitation. The alert note, dated 3/21/26 at 9:38 p.m., for a resident to resident altercation revealed Resident #10 was peacefully in his room with a one-to-one caregiver. Resident #10 believed that people were stealing from him and at this time he seemed calmer. The resident was started on Zyprexa (antipsychotic medication) at 2.5 milligrams (mg) after the situation (with Resident #15).III. Staff interviewsThe chief nursing office was interviewed on 4/30/26 at 8:00 a.m. The chief nursing officer said this was the first altercation between Resident #10 and Resident #15.The NHA was interviewed on 4/30/26 at 9:52 a.m. The NHA (continued on next page)

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	065221	A. Building B. Wing	04/30/2026

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said this was the first altercation between Resident #10 and Resident #15. The NHA said the physical altercation occurred in the dining room. The NHA said the root cause was that Resident #10 said he had some papers that had $400.00 in them. The NHA said to his knowledge, Resident #10 did not have the money. The NHA said Resident #10 felt that Resident #15 took the money. The NHA said no staff members witnessed the incident. The NHA said some residents in the dining room at the time of the incident collectively said that Resident #10 hit Resident #15 on the side of the face. The NHA said Resident #15 did not have to go to the hospital. The NHA said Resident #10 was placed on a one-to-one caregiver because his paranoia caused him to escalate and he became fixated on an issue. The NHA said Resident #10 de-escalated when staff talked with him. The NHA said the resident would suddenly calm down and offer an apology. The NHA said Resident #10 and Resident #15 did not live in the same room and did not live in the same hallway. The NHA said when interviewed, neither of the two residents were afraid of each other. The NHA said the one-to-one caregiver for Resident #10 was continued until 4/7/26.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 reviews and interviews, the facility failed to ensure one (#9) of eight residents out of 40 sample residents received treatment and care in accordance with professional standards of practice.Specifically, the facility failed to:-Ensure physician's orders for wound care were continued after a hospitalization for Resident #9; and,-Ensure Resident #9's wound was addressed in a timely manner by the wound care physician. Findings include:I. Resident #9A. Resident statusResident #9, age [AGE], was admitted on [DATE], was discharged to the hospital on 4/7/26 and returned to the facility on 4/9/26, discharged to the hospital on 4/11/26 and returned to the facility on 4/13/26. According to the April 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with diabetic chronic kidney disease, muscle weakness, morbid obesity, hypo-osmolality (water retention) and hyponatremia (low sodium), and dependence on renal dialysis.The 4/21/26 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. She was partial to moderate assistance with dressing upper and lower body and with showers. She was substantial to maximum assistance with toileting and was incontinent of bowel and bladder. The MDS assessment did not indicate Resident #9 had a wound.B. Resident interviewResident #9 was interviewed on 4/27/26 at 4:00 p.m. The resident said she had skin issues on her bottom and a newer one on her abdomen. Resident #9 said she had treatment for her abdomen now after she saw another physician, but it took a few weeks. Resident #9 said she notified the nurse about the abdomen skin issue a few weeks ago, but nothing was done and now she had a hole in her side. C. Record reviewThe 3/29/26 progress note documented the resident complained of a cyst to the left abdomen. The area was measured at 1 centimeter (cm) by 0.5 cm. The note documented no drainage was observed, barrier cream was applied. The 3/30/26 progress note documented a certified nurse aide (CNA) alerted the nurse to an open area on Resident #9's abdomen. The resident said no one had looked at it and it had been there a few days. The assessment included a measurement of 2 cm by 1 cm open area with yellowish/white center with no drainage. The note documented the surrounding area was slightly red and cool to the touch. The area was cleaned and a dressing was applied. The physician and wound care team were notified. -However, the assistant director of nursing (ADON), who was also the wound nurse, said she was not aware of the wound until she worked a shift as a CNA on 4/16/26 (see interview below).The 3/30/26 physician progress note documented a new wound measuring 2 cm by 2 cm under the pannus (lower abdominal area). The resident agreed to have the wound care team evaluate. The physician recommended the wound care team to evaluate and to monitor for signs of infection to include erythema (redness), drainage and fever.The 3/31/26 progress note documented new interventions to include wound care referral, clean, dry and temporary bandage applied with monitoring orders in place. Review of the April 2026 CPO revealed the following physician's order: Monitor the wound to the abdomen every shift and keep the area clean and dry. Notify the physician with any changes, ordered on 3/31/26 and discontinued on 4/9/26, the date the resident returned from the hospital. -Review of the resident's electronic medical record (EMR) revealed the resident was admitted to the hospital on [DATE] and returned to the facility on 4/9/26. The resident was admitted to the hospital for a laceration to her scalp after a fall in the facility.The 4/9/26 nurse practitioner (NP) note documented to continue with wound care protocol and monitor for infection for the wound under the pannus. -However, the treatment assessment record (TAR) documented the order to monitor wound to abdomen every shift and keep area clean and dry and notify the physician with any changes was discontinued on 4/9/26. The 4/10/26 wound general note documented the resident was not present in the facility for wound rounds. She was not seen by the wound care physician. -Review of the resident's EMR revealed the resident was admitted to the hospital on [DATE] and returned to the facility on 4/13/26. The resident was sent to the hospital from her dialysis appointment due to low sodium.-Review of the April 2026 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the facility failed to obtain new wound care orders for the resident's wound on her abdomen when she was readmitted to the facility on [DATE].The 4/14/26 wound general note documented the resident was not in the building for wound rounds. She was not seen by the wound care physician. The 4/18/26 weekly skin check evaluation documented the resident had a left iliac crest site (near the left hip bone) that had a mediplex covering (foam dressing) the area with erythema and small drainage present, no odor, and no periwound (skin surround a wound) ecchymosis (bruising). The 4/20/26 progress note documented the resident had an open area to the abdomen. The 4/21/26 progress note documented the resident had an open area to the abdomen. The 4/24/26 wound care management progress note documented the resident told the physician the left lower wound was a boil that drained yellow fluid. The physician debrided the wound and ordered silver alginate (wound care dressing pad) dressing to the wound bed, border gauze topper one time a day every Monday, Wednesday and Friday. -However, review of the resident's EMR revealed the facility failed to obtain and provide treatment orders for the resident's wound after she was readmitted from the hospital on 4/13/26 until 4/24/26.The 4/24/26 wound weekly observation tool documented there was a popped boil or cyst on the left lower abdomen with 100 percent (%) slough pre sharp debridement (removal of dead, damaged or infected tissue to promote healing), 100% biofilm (bacteria) reduction post sharp debridement. The wound had moderate serous drainage (fluids from wounds) . The wound measured 1.5 cm by 0.8 cm by 0.3 cm. The wound was deeper around the two o'clock position. Sharp debridement was performed. D. Staff interviewsThe ADON was interviewed on 4/29/26 at 2:25 p.m. The ADON said when a new skin issue was identified the nurse communicated this by writing in a wound care binder located at the nurses' station. The ADON said the binder informed the ADON of any new issues that needed to be addressed. The ADON said she assessed new skin issues without the wound care physician. The ADON said on 4/16/26 she worked Resident #9's hall as a CNA and notified the nurse there was a wound on Resident #9's abdomen. She said this was the first time she was aware of the abdomen wound. The ADON described the wound as having slough on 4/16/26. She said at that time the mediplex was changed to border gauze. She said she removed the mediplex covering that was placed when the resident was in the hospital and returned on 4/13/26. She said the facility needed a new order for a change in mediplex. -However, review of progress notes and physician's orders revealed there was no documentation of the wound covering being changed or communication with the physician requesting an order for a new dressing.The ADON said the wound care physician was in the building once a week. She said rounds were dependent on the physician's schedule and cannot be changed. She said however the visit could be rescheduled if the ADON was unable to attend, but was not changed for residents' schedules. The ADON said Resident #9 was seen on 4/24/26 by the wound care physician and the wound was stable, there was a deep area, it was open and there was slough present.The wound care physician was interviewed on 4/30/26 at approximately 11:40 a.m. The wound care physician said Resident #9 did have a wound on the abdomen when she assessed her on 4/24/26. She said she did not know if the wound started as a boil as she only saw it when it was opened. She said she would have expected the wound to be monitored for infection, cleansed and covered if it was draining until she was able to assess the wound.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of infectious diseases on four out of six hallwaysSpecifically, the facility failed to ensure blood sugar glucometers were disinfected appropriately between residents. Findings include: I. Professional referenceAccording to the centers for disease control (CDC), Conditions for Blood Glucose Monitoring and Insulin Administration, retrieved on 5/6/26 from https://www.cdc.gov/injection-safety/hcp/infection-control/?CDC_AAref_Val=https://www.cdc.gov/injectionsafe Clean and disinfect blood glucose meters after every use, per the manufacturer's instructions. Blood glucose meters can easily become contaminated during use. When used in healthcare or other group settings, germs and infections can spread if preventive measures are not in place.Dedicated meters should be stored in a manner that prevents cross-contamination and inadvertent use for the wrong patient. Establish responsibility for oversight of infection control activities. Provide infection control training for staff members who assume responsibilities for fingersticks and injections.II. Facility policy and procedureThe Glucometer Disinfection policy date revised 1/21/26, was provided by the chief nursing officer on 4/29/26 at 6:42 p.m. Glucometers will be cleaned and disinfected after each use and according to the manufacturer's instructions, regardless of whether they are intended for single resident or multiple resident use.Using the first wipe, clean first to remove heavy soil, blood, and/or other contaminants left on the surface of the glucometer. After cleaning, use a second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. Allow the glucometer to air dry.III. ObservationsOn 4/28/26 at 11:10 a.m. registered nurse (RN) #2 performed a blood glucose test on a resident and failed to clean the glucose monitor before placing it in a plastic bag that was labeled with the resident's name. On 4/29/26 at 4:02 p.m. the assistant director of nursing (ADON) performed a blood glucose test on a resident and failed to clean the glucose monitor before placing it in a plastic bag that was labeled with the resident's name and securing it in the medication cart. On 4/30/26 at 10:41 a.m. RN #4 performed a blood glucose test on a resident and failed to clean the glucose monitor before placing it in a plastic bag that was labeled with the resident's name. IV. Staff interviewsRN #2 was interviewed on 4/28/26 at 11:22 a.m. RN #2 said she should have cleaned the glucose monitor before putting it away. The ADON was interviewed on 4/29/26 at 4:12 p.m. The ADON said she planned to clean all the glucose monitors at the end of her shift. She said she should have cleaned the glucose monitor after each use.The chief nursing officer was interviewed on 4/29/26 at 5:30 p.m. The chief nursing officer said the glucometers needed to be disinfected after each use. She said she reminded the nurses earlier in the morning to ensure the glucometers were disinfected after each use and was providing education. RN #4 was interviewed on 4/30/26 at 11:10 a.m. RN #4 said he should clean the glucose monitor after each use. He should have cleaned it before securing it in the plastic bag and placing it in the medication cart.V. Follow upThe chief nursing officer provided documentation on 4/29/26 at 6:42 p.m. that indicated education was provided to the nurses on 4/29/26 regarding cleaning the glucometers. The education read, Properly cleaning and disinfecting your glucometer is essential to prevent the spread of bloodborne pathogens like Hepatitis B, Hepatitis C, and HIV. While cleaning refers to removing visible dirt or blood, disinfecting is the process of killing germs and microorganisms.Frequency: Meters must be cleaned and disinfected after every use. The glucometers will be disinfected with a wipe pre-saturated with an EPA-registered healthcare disinfectant that is effective against Human Immunodeficiency Virus HIV), Hepatitis C, and Hepatitis B virus. Ensure glucometers are allowed to sit for the appropriate dwell time.