STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065257	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Storybrook Care & Rehabilitation	1005 E Elizabeth St Fort Collins, CO 80524

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews , the facility failed to provide a safe, clean, comfortable and homelike environment for the residents on two out of three hallways and one out of two dining rooms. Specifically, the facility failed to: -Ensure there were enough clean linens; and, -Maintain clean floors in the residents' rooms, hallways and main dining room. Findings include: I. Failure to ensure there were enough clean linens A. Facility policy and procedure The Laundry policy, dated October 2025 was provided by the nursing home administrator (NHA) on 6/3/25 at 2:30 p.m. It read in pertinent part, The facility launders linens and clothing in accordance with current CDC (Center for Disease Control and Prevention) guidelines to prevent transmission of pathogens. Laundry will be removed from washers promptly and will not be left in the machines overnight. B. Resident interviews Resident #5 was interviewed on 6/2/25 at 11:49 a.m. She said she did not get a shower last week, because the facility did not have any clean linens. Resident #7 was interviewed on 6/2/25 at 3:17 p.m. She said it seemed like the facility did not have enough linens. She said there had been times when she did not get her bed bath due to not having any linens. Resident #2 was interviewed on 6/3/25 at 9:58 a.m. She said the facility never had enough linens or towels and it has been an ongoing issue. C. Record review (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065257	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Storybrook Care & Rehabilitation	1005 E Elizabeth St Fort Collins, CO 80524

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility census was provided by the NHA on 6/2/25 at 10:41 a.m. The census documented that the facility had a total census of 52 residents. D. Observations On 6/3/25 at 10:32 a.m. the linen storage closet was stocked with three flat sheets, two large washable chucks pads, four hand towels, four pillow cases, twelve wash cloths, a small shelf of regular towels, five blankets and zero fitted sheets. On 6/3/25 at 10:46 a.m. the washer and dryers in the laundry room were running. There were no clean linens being folded or stored anywhere in the room. C. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 6/3/25 at 10:32 a.m. She said the facility did not have enough linens. She said she noticed the lack of linens when the facility was purchased by a new company. She said there were never any linens after Friday. She said that staff always tried to give the residents their showers even when there were not any towels. She said they would have to get creative and would use the hospital blankets and regular blankets. Laundry aide (LA) #1 was interviewed on 6/3/25 at 10:46 a.m. She said she was not sure if the facility was low on linens. She said the facility had ordered blankets and fitted sheets a few months ago. The maintenance supervisor (MS) was interviewed on 6/3/25 at 11:15 a.m. He said he began working at the facility two months ago. He said he recently discovered that there had been stains on the linens and the staff had been throwing the linens away. He said he had not been taught to order linens and was not sure if he would be taking over that duty. He said the NHA was the person who was in charge of ordering the linens. He said the NHA was aware of the situation. He said the NHA had not ordered any more linens, since they discovered the staff was disposing of the stained linens. The director of nursing (DON) was interviewed on 6/3/25 at 12:02 p.m. She said she was not aware that the residents had not been receiving their showers due to the shortage of linens. She said the lack of linens had been an ongoing issue. She said there had been times when she had to go to the laundry room and grab linens so that the floor staff would have enough for their shift. She said the laundry staff needed more education regarding cleaning the linens. She said the laundry staff needed education regarding washing the sheets to see if the stains could be removed prior to disposing of them. The NHA was interviewed on 6/3/25 at 12:15 p.m. She said the facility did not have a shortage of linens. She said there was a lack of awareness of where linens were being held. She said the laundry staff was supposed to stock the linen closets but sometimes they did not stock it enough. She said the floor staff did not go downstairs to get more linens. She said that the laundry room was locked on the weekends and there was a disconnect between the laundry staff and the floor staff. She said the facility had an upcoming meeting with the linen supplier to go over par levels. She said she did not know the current par levels for linens. II. Failure to maintain clean floors in the residents' rooms, hallways and main dining room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065257	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Storybrook Care & Rehabilitation	1005 E Elizabeth St Fort Collins, CO 80524

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Observations On 6/2/25 at 11:00 a.m., during the initial walk-through of the facility, the main hallway floors on all the units had wrappers from snacks, wheelchair tracks on the floors, spots where liquids were dropped and then dried and dust in the corners. In room [ROOM NUMBER] there were wheelchair tracks and dried liquid spots were on the floor. In room [ROOM NUMBER] there was black debris that outlined the resident's personal belongings that were placed on the floor. In room [ROOM NUMBER] the floor had dust in the corners and spills that had dried. The dining room had food and beverage spills on the floor and visible wheelchair tracks. B. Staff interviews Housekeeper (HK) #1 was interviewed on 6/3/25 at 11:06 a.m. She said she began working at the facility two months ago. She said there were two housekeepers during the week and one on the weekends. She said the facility hired a new housekeeper that was starting sometime that week. She said there were paper schedules that documented which rooms they were supposed to clean. She said the schedules were where they were supposed to document what they cleaned and if there were any needed repairs. She said they cleaned the dining room, shower rooms, employee and guest bathrooms every day. She said they cleaned the long hall and short hall every other day. The MS was interviewed on 6/3/25 at 11:15 a.m. He said that the residents' rooms and dining room were cleaned every day. He said everything was tracked on paper schedules. He said he was unsure how often the residents' rooms should be deep cleaned. He said he was not sure when the housekeepers cleaned the dining room, but he often saw them there in the mornings. He said he did not know if the housekeepers swept and mopped the dining room after each meal. He said he had three full-time employees. He said Sunday through Tuesday there were two housekeepers. He said on Wednesday there were three housekeepers and Thursday through Saturday there was one employee. He said he did not think that one employee would be able to clean all the residents' rooms, bathrooms, shower rooms and dining room by themselves.