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	10/15/2025

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#6) of four residents were kept free from physical abuse out of 10 sample residents.Specifically, the facility failed to ensure Resident #6 was kept free from physical abuse by Resident #3. Findings include:I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy, implemented on 10/16/24, was provided by the nursing home administrator (NHA) on 10/13/25 at 9:54 a.m. The policy revealed the facility would provide protections for the health, welfare and rights of each resident by developing, implementing written policies with procedures that prohibited and prevented abuse, neglect, exploitation and misappropriation of resident property. The term abuse meant 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 develop and implement written policies and procedures that prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property. The facility would establish policies and procedures to investigate any such allegations; include training for new and existing staff on activities that constituted abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention; and establish coordination with the quality assurance performance improvement (QAPI) program.The facility would designate an Abuse Prevention Coordinator in the facility who was responsible for reporting allegations of suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. The facility would provide ongoing oversight and supervision of staff in order to assure that its policies were implemented as written.The facility would implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation. The facility would identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property was more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents. The facility would assure that the staff assigned had knowledge of the individual residents' care needs and behavioral symptoms; the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.The facility would have written procedures to assist staff in identifying the different types of abuse mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This included staff to resident abuse and certain resident-to-resident altercations. Possible indicators of abuse included, but were not limited to the observations of physical abuse of a resident.II. Incident of physical abuse between Resident #3 and Resident #6 on 7/23/25A. Facility investigationThe 7/23/25 at 6:28 p.m. alleged abuse risk report revealed Resident #3 struck the arm of Resident #6. The residents were immediately separated. Resident #3 was oriented to her person. Skin assessments were completed and no injuries were observed.The investigation revealed the outcome of the investigation found no intentional, knowing or reckless actions resulting in bodily injury. The investigation documented Resident #6 was unable to recall the incident. Resident #6 resided in the memory care unit and had severe cognitive impairment. Resident #6 voiced no concerns at the time of the interview on 7/24/25 by the NHA. Resident #6 was asked by the NHA if she felt safe and Resident #6 answered yes. The investigation documented Resident #3 was interviewed on 7/24/25 by the NHA. Resident #3 resided in the memory care secure unit and had severe cognitive impairment. The resident was unable to recall the altercation. The investigation documented the facility could not substantiate the abuse because it failed to meet criteria.-However, abuse occurred due to Resident #3 striking Resident #6's arm.B. Resident #3 - assailant1. Resident statusResident #3, age greater than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included adult failure to thrive, bilateral hearing loss, major depression, difficulty in walking, spinal stenosis in the lumbar region and dementia

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 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 residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for two (#7 and #5) of seven residents reviewed for quality of care out of 10 sample residents.Specifically, the facility failed to:-Ensure Resident #7 and Resident #5 were assessed by a registered nurse (RN) following falls; and,-Ensure Resident #7, who was on anticoagulant medication (a class of medications that prevent or slow down blood clotting and can increase the risk of bleeding), received consistent and increased monitoring following a fall on 7/25/25 where the resident hit her head. The resident was transported to the emergency room three days post-fall, where she was diagnosed with a significant subdural hemorrhage (bleeding in the brain). Resident #7, who was known to be at risk for falls, was admitted on [DATE] with diagnoses of displaced intertrochanteric fracture of the right femur, atrial fibrillation, muscle weakness and difficulty in walking. Resident #7 was taking Eliquis (an anticoagulant, blood thinner) for atrial fibrillation (a condition where the upper chambers of the heart (atria) beat irregularly and rapidly, which disrupts the normal rhythm of the heart and can lead to complications, such as blood clots and stroke).On 7/25/25 Resident #7 sustained a fall in the early morning hours where she hit her head. After the fall, a licensed practical nurse (LPN) evaluated the resident and the resident was determined not to have any injuries from the fall. However, review of Resident #7's electronic medical record (EMR) failed to reveal that a RN had assessed the resident at the time of the fall or that a RN was consulted regarding the resident's fall. Resident #7 began complaining of a headache and neck pain later in the morning on 7/25/25, however, the facility did not send the resident out to the emergency department for further evaluation, despite the fact that the resident was on anticoagulant medication and had hit her head during her fall. Documentation did not indicate the facility increased monitoring for Resident #7 for potential signs of bleeding in the brain after she hit her head during the fall, aside from implementing the facility's normal neurological assessment protocol. Interviews during the survey revealed the facility's process for neurological assessments included monitoring residents for 72 hours post-fall. However, review of the implemented neurological assessments for Resident #7 revealed neurological assessments on 7/26/25 and 7/27/25 were not completed consistently as scheduled.On 7/28/25, three days after the fall, Resident #7 was transported to the emergency department for uncontrolled pain in the back of her head and vomiting. A computed tomography (CT) scan conducted at the hospital revealed the resident had sustained a significant subdural hemorrhage from the fall.The facility's failures to frequently and consistently monitor Resident #7, who was on anticoagulant medication, following a fall where she hit her head resulted in the delay of the resident being transferred to the hospital where it was identified that she had sustained a significant brain bleed.Additionally, the facility failed to ensure Resident #5 was assessed by a RN prior to being moved from the floor after the resident's fall on 4/8/25.Findings include: I. Professional referenceAccording to Nurse Journal's Licensed Practical Nurses (LPN) Versus Registered Nurses (RN), (8/27/24), retrieved on 10/15/25 from https://nursejournal.org/resources/lpn-vs-rn-roles/, LPNs and RNs both monitor patients, administer medications, perform wound care, help patients with basic tasks like bathing and feeding, and often educate and support patients and their loved ones. However, there are differences in the education requirements and scope of practice between RNs and LPNs. LPNs perform vital work in collaboration with RNs, physicians and other healthcare professionals. LPNs work alongside or under the supervision of RNs to deliver care and support to patients. This role also requires gathering patient data, which other licensed healthcare providers later interpret. Unlike RNs, LPNs typically do not have state authorization to make health assessments, create nursing care plans or triage patients. Compared to LPNs, RNs generally operate independently. RNs use their specialized judgment, skills, and knowledge to provide direct patient care in various settings. Generally speaking, only RNs provide initial assessments. Therefore, an RN must perform all tasks that require close monitoring and frequent assessment, such as initiating blood products, the first round of antibiotics, and initial patient assessments.According to Science Direct's Brain hemorrhages in traumatic brain injury and the excess burden conferred by anticoagulants and antiplatelets (10/19/24) retrieved on 10/22/25 from https://www.sciencedirect.com/science/article/pii/S2589238X24000457, Geriatric trauma patients along with their preexisting comorbidities are often on anticoagulants that increase their risk for complications, bleeding, mortality in the setting of even minor traumas. With a geriatric population, less severe injuries and minimal