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	12/22/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review and interviews, the facility failed to ensure the services provided or arranged by the facility met professional standards of quality for one (#7) of two residents out of nine sample residents. Specifically, the facility failed to ensure professional standards were followed when completing a peripherally inserted central catheter (PICC) line dressing for Resident #7.Findings include:I. Professional referenceThe University of California Los Angeles (UCLA) Health's Care and Maintenance of Peripherally Inserted Central Catheters (PICC) (2026), retrieved on 1/5/26 from https://www.uclahealth.org/medical-services/radiology/clinical-services/clincal-programs/peripherally-inserted-central-catheters-picc/care-and-maintenance, read in pertinent part, PICC line dressing steps: -Perform hand hygiene with hospital approved waterless alcohol gel or foam cleaning solution or, if visibly soiled, wash hands with soap and water for 20 seconds;-Apply clean gloves;-Apply mask to patient or ask patient to turn head away from catheter site;-Apply personal protective equipment (PPE) such as gown and cap per protocol;-Remove dressing and dispose in waste container;-Remove gloves and dispose in waste container;-Perform hand hygiene with hospital approved waterless alcohol gel or foam cleaning solution or, if visibly soiled, wash hands with soap and water for 20 seconds;-Apply sterile gloves;-Pinch the wings on the Chlorhexidine-70% alcohol applicator to break the ampule and release the antiseptic onto the sponge pad;-Clean area approximately two inches around the catheter exit site with the chlorhexidine applicator. Use a back and forth motion for 30 seconds to clean site;-If using alcohol and povidone iodine, clean in a circular motion from the PICC exit site outwards approximately two inches in diameter;-Allow the area to air dry for 30 seconds;-Secure catheter with Advance CHG Tegaderm and/or suture-less securement device; -Note date, time and initials on dressing; and,-Document the date and time of the procedure and assessment of the site in the patient's medical record. Sterile fields must always be kept in sight to be considered sterile. Sterile fields must always be kept in sight throughout the entire sterile procedure. Never turn your back on the sterile field as sterility cannot be guaranteed.II. ObservationsOn 12/22/25 at 1:14 p.m. registered nurse (RN) #1 was observed performing a PICC line dressing change for Resident #7. RN #1 was observed turning his back on the sterile field several times during the PICC line dressing change. RN #1 left the resident's room to grab additional supplies after removing the PICC line dressing, leaving the resident's PICC line exposed. RN #1 cleaned the distal (far end) section of the PICC line first, and then proceeded to clean the insertion site last with the chlorhexidine sponge for less than the recommended 30 seconds (see professional reference above). -RN #1 failed to measure the length of the catheter to monitor for migration (the unintended shifting of the catheter from its ideal position often due to patient movement, coughing or change in body position). RN #1 wore gloves and a mask during Resident #7's PICC line dressing change, however RN #1 failed to don a protective gown during the PICC line dressing change. Cross-reference F880 for failure to ensure enhanced barrier precautions (EBP) were followed during a PICC line dressing change. III. Record reviewThe employee file for RN #1 was reviewed on 12/22/25 at 4:15 p.m. RN #1's employee file did not contain documentation that he had completed training and competency to show he was able to demonstrate skills and techniques necessary to perform an appropriate PICC line dressing change.IV. Staff interviews RN #1 was interviewed on 12/22/25 at 2:17 p.m. RN #1 said he had worked at the facility for less than two months. RN #1 said he had experience with changing PICC line dressings from his previous employment. RN #1 said he had not received any formal training on PICC line dressing changes from the current facility. RN #1 said he would like education and training from the facility. RN #1 said he was nervous while performing Resident #7's PICC line dressing change and that is the reason he failed to complete the procedure in the appropriate steps (see observation above). RN #1 said he knew that he was not supposed to leave the resident's PICC line exposed and instead should have used the call bell to request other staff members to bring him additional supplies. The director of nursing (DON) and the infection preventionist (IP) were interviewed together on 12/22/25 at 3:47 p.m. The IP said he also performed the role of the staff development coordinator and was in charge of nursing training. The IP said the facility was in the process of initiating a new training platform for all nursing staff. The IP said competency training had not yet started on the new training platform. The IP said the manner in which RN #1 completed the PICC line dressing change for Resident #7 was not the standard of care. The IP said it was important to follow the standard of care to prevent infections, protect resident safety and promote consistent high quality care. The DON said she had two nurses currently working in the facility. The DON said neither of the nurses had received training for PICC line management

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations and interviews, the facility failed to ensure infection prevention and control programs (IPCP) were maintained and followed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on one of two units. Specifically, the facility failed to ensure enhanced barrier precautions (EBP) were followed during a peripherally inserted central catheter (PICC) line dressing change.Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 12/30/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, It read in pertinent part,Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing.II. Facility policy and procedureThe Transmission Based Precaution policy, implemented 10/16/24, was received from the director of nursing (DON) on 12/22/25 at 2:10 p.m. The policy read in pertinent part, It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. Airborne precautions refer to actions taken to prevent or minimize the transmission of infectious agents/organisms that remain infectious over long distances when suspended in the air. Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Droplet precautions refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Transmission-based precautions (also known as Isolation Precautions) refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact and droplet) in order to prevent or control infections. The facility will use standard approaches, as defined by the CDC, for transmission-based precautions: airborne, contact, and droplet precautions. The category of transmission-based precautions will determine the type of personal protective equipment (PPE) to be used. Facility staff will apply transmission-based precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission.-However, the policy failed to mention or address enhanced barrier precautions (EBP).III. Observations and resident interviewOn 12/22/25 at 12:00 p.m. there was a sign on Resident #7's door that indicated the resident was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. Resident #7 was interviewed on 12/22/25 at 12:05 p.m. Resident #7 said he came to the facility for antibiotic treatment and intravenous (IV) management. He said the nurses were really nice but they never wore gowns or a mask when giving him his IV antibiotics. He said he was unsure if there were any requirements for the nurses to wear gowns or masks when he would get his IV medication. On 12/22/25 at 1:14 p.m. registered nurse (RN) #1 was observed performing a PICC line dressing change for Resident #7. -RN #1 wore gloves and a mask during Resident #7's PICC line dressing change, however RN #1 failed to don a protective gown during the PICC line dressing change. On 12/22/25 at 1:45 p.m. certified nurse aide (CNA) #2 was assisting Resident #7 with transferring from his wheelchair to the private toilet in his room. -However, CNA #2 failed to put on a protective gown prior to providing incontinence care to Resident #7.IV. Staff interviews CNA #2 was interviewed on 12/22/25 at 2:08 p.m. CNA #2 said Resident #7 needed staff assistance to get out of his bed into his wheelchair and from his wheelchair onto the toilet. She said Resident #7 was on EBP because of his