STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065377	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centre Avenue Health and Rehab LLC	815 Centre Ave Fort Collins, CO 80526

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#1 and #20) of six residents out of 20 sample residents were free from significant medication errors. Specifically, the facility failed to:-Prevent Resident #20 from a missed administration of a rapid-acting insulin dose; and,-Prevent Resident #1 from receiving the wrong dose of a long-acting insulin.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 5/20/26 to 5/21/26, resulting in the deficiency being cited as past noncompliance with a correction date of 4/27/26.I. Incidents of insulin administration failures for Resident #20 and Resident #1On 4/8/26 at 7:00 a.m. registered nurse (RN) #2 failed to check Resident #20's blood sugar before breakfast and did not administer three units of insulin aspart (a rapid acting insulin with a duration lasting three to five hours), as ordered by the physician. Due to RN #2's failure to monitor and administer the physician ordered insulin, Resident #20's blood glucose level (measure of the amount of sugar present in the blood) increased to 600 milligrams per deciliter (mg/dl) later that afternoon (4/8/26).On 4/24/26 at 7:40 p.m. RN #1 obtained Resident #1's blood sugar, which was 127 mg/dl, and administered the resident's scheduled dose of three units of insulin glargine (a long lasting insulin with a duration of 24 hours). However, RN #1 inadvertently administered 30 units of insulin glargine instead of the physician ordered dose of three units.Due to RN #1's failure to ensure the correct dose of insulin was administered to Resident #1, the resident's blood glucose level decreased to 60 mg/dl and the resident experienced lethargy and difficulty staying awake. II. Facility plan of correctionThe corrective action plan the facility implemented in response to the incidents of the missed insulin administration for Resident #20 on 4/8/26, and the administration of the wrong dose of insulin for Resident #1 on 4/24/26 was provided by the chief nursing officer on 5/21/26 at 10:37 a.m.The corrective action plan documented the following: A. Immediate action for affected residents included the following:RN #2 notified the provider Resident #20's missed administration of the resident's morning insulin dose on 4/8/26. RN #2 was educated on 4/9/26 to prioritize diabetic medications in the morning and to ask for assistance if running behind on work.On 4/24/26 the facility notified the provider, the resident's representative and the director of nursing (DON) regarding Resident #1 receiving the wrong dose of insulin on 4/24/26.Resident #1 was notified of the medication error on 4/24/26 and was educated on signs and symptoms of low blood sugar and the use of glucagon (an emergency treatment for low blood sugar). Resident #1 was given orange juice, peanut butter, crackers and candy in response to the incorrect insulin administration. Resident #1 was placed on alert charting highlighting blood glucose checks every three hours initially and then increased to every one hour blood glucose checks. Education in response to the insulin medication error was provided to RN #1 by the DON on 4/24/26. RN #1 was observed during insulin administration on 4/25/26 to ensure she followed safe practices. Education was provided to charge nurses on 4/25/26 which included reviewing insulin orders in detail prior to administration.The medical director was notified on 4/25/26 by the on-call nurse practitioner of the insulin overdose administered to Resident #1 (on 4/24/26). B. Identification of other residents having the potential to be affected by the deficient practiceThe facility documented 11 additional residents that required insulin for treatment of diabetes mellitus. C. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Measures or systemic changes to ensure the deficient practice will not recurThe facility documented the completion of a house wide audit on 4/25/26, which included a review of all current residents' insulin orders to determine if insulin had been correctly administered. The facility documented nursing staff education was completed on 4/25/26. The education included the rights of medication administration and a review of critical medications and documentation of online training titled The Dangers of Medication Administration. The nursing staff education additionally included the implementation of the use of a second nurse for verification of insulin orders during medication administration. The facility documented completion of insulin administration audits and competencies on 4/25/26 for nursing staff who were at the facility at the time and who routinely administered insulin. The facility plan included audits of insulin orders, insulin administration documentation and second nurse verification of insulin administration documentation daily for twelve weeks. The facility documented an ad hoc (spontaneous discussion scheduled to address an unexpected concern) quality assurance and performance improvement (QAPI) meeting on 4/27/26 with the medical director (MD), the nursing home administrator (NHA), the DON, the social services director (SSD) and the clinical manager determined the necessary re-education of all nursing staff which included: -Education about critical medication and insulin dosing before administration and the10 Rights of Medication Administration; -The addition of supplemental documentation which included second nurse verification; -Staff education (Rights of Medication Administration, critical medications), and through the online education (The Dangers of Medication Administration); and,-Insulin administration audits and competencies were initiated for nursing staff who routinely administered insulin.D. Plan to monitor for sustained complianceThe facility documented nursing leadership would be auditing residents' insulin orders and administration documentation and second nurse verification of insulin administration daily for 12 weeks.Nurses would be observed administering insulin by the DON or the pharmacist or designee.The facility documented the initiation of a QAPI Performance Improvement Project (PIP) on 4/27/26 for monitoring corrective action and the facility's plan was to review findings at the monthly QAPI meeting for a minimum of three months. The facility documented adjustments would be made to the plan to ensure sustained compliance. E. The facility documented the date of compliance was 4/27/26. III. Facility policy and procedure The Medication Administration policy, revised 5/6/26, was provided by the chief nursing officer on 5/21/26 at 4:59 p.m. It read in pertinent part, Ensure that the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time, and right documentation. Review medication administration records (MAR) to identify medication to be administered.The Medication Errors policy, implemented 4/11/26, was provided by the chief nursing officer on 5/12/26 at 4:59 p.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. The facility will ensure medications will be administered according to physician orders. Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety. IV. Resident #20 A. Resident statusResident #20, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included diabetes mellitus, long term use of insulin, glaucoma, scoliosis and chronic lower back pain. The 4/30/26 minimum data set (MDS) assessment identified Resident #20 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment revealed the resident used a wheelchair, and required assistance with transfers, bathing, dressing and her vision was highly impaired.The MDS assessment indicated the resident received insulin injections. B. Resident interviewResident #20 was interviewed on 5/21/26 at 2:00 p.m. Resident #20 said she had diabetes for many years and always wanted to know her blood glucose levels and insulin dosages so she could keep track of her diabetes. She said she sometimes had felt symptoms of high or low blood sugars and she would let the nurses know when she had felt symptoms. C. Record reviewThe diabetes care plan, initiated 11/24/25, revealed Resident #20's potential for complications, (continued on next page)

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