STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065414	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coal Creek Post Acute & Assisted Living	329 Exempla Cir Lafayette, CO 80026

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 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 interviews and record review, the facility failed to ensure residents were free from any significant medication errors for one (#4) of six residents reviewed out of 18 sample residents.Specifically, the facility failed to ensure Resident #4 did not receive Resident #11's medications in addition to his own medications.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 6/1/26 to 6/3/26, resulting in the deficiency being cited as past noncompliance, with a correction date of 12/26/25.I. Situation of failure to administer medications as orderedResident #4 was admitted to the facility on [DATE] with a computerized physician's order (CPO) for his medications, which he received correctly on 12/23/25 and 12/24/25. On the morning of 12/25/25, Resident #4 received his medications, plus six medications belonging to Resident #11. On 12/25/25 Resident #4 was transferred to a local hospital, unrelated to the incorrect medication administration, where the medication errors were discovered. Upon investigation of the incident, the facility identified the following:On the afternoon of 12/24/25, the medical records director (MRD) electronically uploaded to the nurse practitioner (NP) what should had been two resident's medical records (Resident #4 and Resident #11). The MRD instead uploaded one resident's (Resident #11) chart twice, once for Resident #11 and once for Resident #4. The NP did not verify the name or date of birth for Resident #4. The NP read Resident #4's correct CPO and made a determination to add eight medication from Resident #11's chart into Resident #4's certified physician's orders. The NP ordered the new medications to begin on 12/25/25.On the morning of 12/25/25, Resident #4 was administered his own medication, plus six of the eight medications from Resident #11's CPO.On 12/25/25 around 1:30 p.m. a nurse noticed Resident 4's PICC line (peripherally inserted central catheter, which was inserted into a vein in the upper arm), was very red, hot, and swollen. Resident #4 was sent to the hospital due to the concern with his PICC line. At the hospital on [DATE], the medication errors were found by the hospital physician, who recognized the medication orders were not the same as from 12/23/26 when the hospital originally discharged Resident #4 to the facility. Resident #4 was immediately placed back on his correct medications at the hospital. Resident #4 only received one dose each of the incorrect medications on the morning of 12/25/25.On 12/25/25 the hospital notified the facility's medical director (MD) of the medication errors.On 12/26/25 the NP who made the error, came into the facility and notified the nursing home administrator (NHA) and the director of nursing (DON) of the mistake. On 12/26/25 the NHA and the DON took immediate action to remedy the situation that had occurred in the facility with Resident #4.On 12/26/25 the facility's MD went to the hospital and met with the hospital's physician, Resident #4, and Resident #4's family representative. The MD determined there was no harm after Resident #4 received one dose of each of the wrong medications. The MD said because it was only one dose, there was no harm done to Resident #4. The MD said the reason Resident #4 went to the hospital on [DATE] was due to his PICC line and not the medication error that occurred in the morning of the same day.On 12/27/25 Resident #4 readmitted to the facility from the hospital. Resident #4's CPO was updated correctly, and Resident #4 received the correct medications until his discharge from the facility on 1/6/26.II. Facility plan of correctionOn 12/26/25 the NHA and the facility's management (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
	065414	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coal Creek Post Acute & Assisted Living	329 Exempla Cir Lafayette, CO 80026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	team met and implemented a plan of action in response to Resident #4's medication errors, in order to ensure that all of the residents in the facility received the correct medications per their physician's orders.A. Immediate actionOn 12/26/25 Resident #4 received his correct medications in the hospital. All residents in the facility had their CPOs reviewed. The DON educated the facility's nursing staff and the MRD. The MD went the hospital to meet with the hospital physician and Resident #4. The MD met and educated all of his providers, including the NP who made the medication error. B. Identification of other residentsOn 12/26/25: The facility printed all current residents' medication discharge summaries, and all current medications. The DON and the prescribing providers reviewed each resident. This was completed on 12/26/25 with all medications verified to be prescribed correctly and orders verified to be current and verified all current orders to be correct as per individual residents. All current order summaries were signed by the provider after review and no variances were noted. All current charts were reviewed for correct documentation uploads and to verify only the resident's documents were uploaded per chart. This was completed on 12/26/25.-All residents admitted within the last 30 days would be audited for provider entered order errors. All providers entered orders to be verified via a chart review and provider note review. Providers to be contacted in case of any variation for collaborative discussion and review. This will be completed no later than 12/31/25.C. Systemic changesOn 12/26/25 the MRD education was completed regarding double verifying uploads were correct as per resident chart. The MRD was to verify all current resident's name and date of birth on all documents and verify they were uploaded to the correct resident's chart. The MD educated his practice (company name) on completing medication reconciliation on admission and any variances were to be communicated to the nursing manager directly for collaborative medication management and reconciliation post discharge.-All admission orders were to be entered by the nursing team with medications verified via two nurse check off prior to order activation. This will be completed on every admission for discharge order reconciliation. The interdisciplinary plan of care (IPOC) check will be completed within 72 hours of admission by the nursing manager for all residents.-The MD's (company name) agreed to only enter new diagnosis/plan of treatment related orders for 72 hours post admission. For any correction to the medication admission orders and discharge medication reconciliation (company name) will not prescribe and enter orders. The (company name) will call the nurse manager directly to discuss, collaboratively manage orders and then nurse manager or designee will enter orders.Beginning 12/26/25, all (resident) discharge documents uploaded to the chart will have a second person's verification of the correct name and date of birth of the resident documents uploaded correctly within 72 hours.D. MonitoringOn 12/26/25: The MD educated that the (company name) providers will not enter any resident discharge orders upon admission to (company name).Starting 12/26/25: The MRD/DON/nurse manager/designees will: document an uploaded review of the resident's discharge summary and an audit to be completed within 72 hours of uploading the discharge summary. The medical records department will do the first audit and the nurse manager or designee is to verify the correct discharge summary uploaded by the medical records department within 72 hours of upload to the resident chart. This will be completed on every resident for 30 days then as determined by the QAPI (quality assurance and performance improvement) committee. This will be documented on an audit tool.A monthly review in the QAPI committee would continue until substantial compliance was achieved.III. Facility policy and procedureThe Medication Administration policy, dated 2022, was provided by the DON on 6/2/26 at 9:00 a.m. via email. It revealed in pertinent part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Identify resident(s) by photo in the MAR (medication administration record).IV. Resident #4A. Resident statusResident #4, age [AGE], was admitted on [DATE], readmitted on [DATE], and discharged on 1/6/26. According to the December 2025 CPO, diagnoses included acute embolism and thrombosis of the superficial veins of the right upper (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065414	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coal Creek Post Acute & Assisted Living	329 Exempla Cir Lafayette, CO 80026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extremities (a blood clot formed near the surface of the skin), sepsis, bacteremia (bacteria in the bloodstream), acute respiratory failure, COPD (chronic obstructive pulmonary disease), type 2 diabetes mellitus and hypertension (high blood pressure).The 12/31/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #4 required maximum assistance with toileting and bathing. Resident #4 required set-up assistance with eating and oral hygiene.B. Record reviewOn 12/23/25 Resident #4 was to receive the following medications per the December 2025 MAR:Atorvastatin calcium 10 mg (milligrams), Ampicillin sodium injection solution 2 gm (grams), Lisinopril 10 mg, Pioglitazone 30 mg, Rosuvastatin 5 mg and Tamsulosin 0.4 mg.On 12/24/25 at 9:49 a.m. the pharmacy progress note documented Resident #4's medication was reviewed with no recommendations.On 12/24/25 at approximately 7:10 p.m. the NP's progress note revealed that Resident #4's medication orders were updated. According to the DON (see interview below), the NP added the incorrect medications and Resident #4 was to receive the updated medications on 12/25/25. (Resident #4 did receive the correct medications on 12/23/25 and 12/24/25.)On 6/2/26 at 10:00 a.m. the MD provided the following medication list of additions that Resident #4 received on 12/25/25.The medication list provided by the MD revealed Resident #4 received the following medications on 12/25/25, which the NP mistakenly added to Resident #4's CPO from Resident #11's medications: Lyrica 100 mg, Spironolactone 25 mg, Losartan 100 mg, Sertraline 100 mg, Sinemet 10-100 mg and Synthroid 88 mcg (micrograms).The 12/26/25 at 1:29 p.m. late entry progress note, written by the DON, documented Resident #4 was sent to the emergency room (ER) (on 12/25/25) for concern for issues with a PICC line. Resident #4 had medication reconciliation completed at the ER with anomalies noted. Upon investigation, root cause analysis revealed the resident had the wrong discharge summary uploaded to the chart and the NP updated orders based on the wrong discharge summary medication list. Resident #4 received minimal doses of the wrong medications with no adverse effects noted. Resident #11 was on correctly ordered medications from his discharge summary medication list.The resident had no adverse effects from medications administered and was subsequently sent to the ER for an unrelated issue. Education to staff and providers was provided on verifying name and resident identifiers in charts prior to entering medication orders. Education was provided to MRD regarding uploads and verifying correct documents in the correct chart.The 12/27/25 hospital physician discharge note documented Resident #4 came to the hospital on [DATE] with right upper arm swelling. There was a concern that Resident #4 had a skilled nursing home medication list which listed medications that were not prescribed. The hospital physician spoke to the nursing home's medical director who indicated that they were aware of the error and had been in the process of correcting the medication list for Resident #4 while he was in the hospital.V. Staff interviewsThe MD was interviewed on 6/1/26 at 3:23 p.m. via the telephone. The MD said he was made aware of Resident #4's medication error when the hospital called and notified him on 12/25/25. The MD said the facility admitted to the error immediately. The MD said on 12/26/25 he went to the hospital where Resident #4 had been admitted . The MD said he personally met with the hospital physician and he and the hospital physician determined there was an error, but the resident did not have any harm with only one dose of the incorrect medications being administered. The MD said he personally met with Resident #4 in the hospital, and talked with Resident #4's family representative about the situation.The DON and clinical resource #1 were interviewed together on 6/1/26 at 4:00 p.m. Both the DON and clinical resource #1 said the problem with the incident with the medication error was that the facility's MRD uploaded into the computer incorrect information. The DON and clinical resource #1 said the MRD, on 12/24/25, uploaded electronically to the NP what was to be two different resident's charts, but instead upload Resident #11's chart for both Resident #11 and Resident #4. The DON said the NP did not verify the name or date of birth for Resident #4. The DON said Resident #11 received his correct medications. The DON said the NP scheduled the new medication changes to begin on 12/25/25. The DON said Resident #4 had received the correct medications on 12/23/25 and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065414	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coal Creek Post Acute & Assisted Living	329 Exempla Cir Lafayette, CO 80026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/24/25, and the incorrect six medications only on the morning of 12/25/25. The DON said when Resident #4 went to the hospital on the afternoon of 12/25/25, the problem was discovered at the hospital and fixed immediately. Clinical resource #1 said the facility immediately fixed the situation on 12/26/25, before Resident #4 returned to the facility on [DATE]. The DON said the NP no longer worked in the facility after the incident.-The DON provided a written and signed statement that the NP wrote on the morning of 12/26/25, which revealed that the NP admitted that she had transcribed another resident's medications in the medical record of Resident #4. The NP notified the DON that the NP's supervisor (the MD) was notified of the mistake.The MD was interviewed again on 6/2/26 at 10:00 a.m. The MD said Resident #4 received the correct medications on 12/23/25 and 12/24/25. The MD said on 12/24/25 the NP had added medications to Resident #4's medical record that belonged to Resident #11. The MD said Resident #4 received his medications on 12/25/25 in the morning plus Resident #11's medications. The MD said on 12/25/25 Resident #4 received one dose of each of the incorrect medications (see above list provided by the MD). The MD said Resident #4 did not receive harm from only one dose of each of the six medications. The MD said had the error gone on for two weeks or a month, there may have been a problem. The MD said he told the NP that the NP should have noticed the medication Sinemet was for Parkinson's disease, and Resident #4 did not have Parkinson's disease. The MD said he had a system in place with the local hospital because the nursing facility was a rehabilitation place. The MD said if the hospital found any problems with any of the residents, the hospital was to call him. The MD said the incident was resolved immediately upon the knowledge of the error, and the medication error had not happened again since the incident with Resident #4. The MD said the follow-up about the medication error continued in the QAPI meetings as well to ensure ongoing compliance.