STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065431	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Centerplace, Llc, The	4356 24th St Rd Greeley, CO 80634

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#5) of five residents received the highest practicable treatment and care in accordance with professional standards of practice of five sample residents.Specifically, the facility failed to ensure:-All prescribed medications which were ordered upon Resident #5's admission, including medications to treat infections, were administered as ordered and when available; and,-Notify the physician when Resident #5 medications were not administered as ordered. Findings include:I. Facility policy and procedureThe IV (intravenous) Medication Administration policy, revised 10/12/22, was provided by the nursing home administrator (NHA) on 11/19/25 at 9:44 a.m. It read in pertinent part, It is the policy of this facility that IV medications are to be administered as prescribed by the attending physician. IV medication must be administered in accordance with the written orders of the attending physician.The Medication Administration policy, revised 8/22/22, was provided by the NHA on 11/19/25 at 10:58 a.m. It read in pertinent part, Medications must be administered in accordance with the written orders of the attending physician. Medications may not be set up in advance and must be administered within one hour before or after their prescribed time.II. Resident #5A. Resident statusResident #5. age less than 65, was admitted on [DATE]. According to the November 2025 computerized physician's orders (CPO), diagnoses included cellulitis (deep bacterial skin infection) of the right lower limb, pressure ulcer of the right hip, diabetes and respiratory failure.The 10/13/25 minimum data set (MDS) assessment revealed Resident #5 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required set up assistance with eating, supervision with personal hygiene and toileting and moderate assistance with showering.B. Resident #5 interviewResident #5 was interviewed on 11/18/25 at 11:45 a.m. Resident #5 said during his most recent admission to the facility, he did not initially receive all of his scheduled medications. Resident #5 said the facility had not missed medication doses since the day after he was admitted .C. Record reviewReview of the October 2025 CPO revealed the following physician's orders upon the resident's admission [DATE]):-Ceftriaxone sodium two gram (gm) IV, with instructions to give once daily for sepsis (infection).-Ferrous sulfate 325 milligrams (mg), with instructions to give once daily for iron deficiency.-Jardiance 10 mg, with instructions to give once daily for diabetes.-Allopurinol 300 mg, with instructions to give once daily for gout.-Bumetanide two mg, with instructions to give every morning for edema.-Potassium chloride ER (extended release) 20 mEq (milliequivalents, a unit for measuring potassium), with instructions to give three tablets once daily for low potassium.-Prednisone four mg, with instructions to give once daily for hypoxia (low oxygen level).-Sertraline 100 mg, with instructions to give once daily for antidepressant.-Tamsulosin 0.4 mg, with instructions to give once daily for BPH (benign prostatic hyperplasia, enlargement of prostate gland).-Apixaban 5 mg, with instructions to give twice daily for anticoagulant (blood thinner).-Carvedilol 12.5 mg, with instructions to give twice daily for hypertension (high blood pressure).-Gabapentin 300 mg, with instructions to give three times daily for diabetic neuropathy. Resident #5 was not administered the following ordered medications which were documented as not available: Ceftriaxone on 10/12/25 at 8:00 a.m.Ferrous sulfate on 10/12/25 at 8:00 a.m.Jardiance on (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/12/25 at 8:00 a.m.Allopurinol on 10/12/25 at 8:00 a.m.Bumetanide on 10/12/25 at 12:00 p.m.Potassium chloride on 10/12/25 at 8:00 a.m.Prednisone on 10/12/25 at 8:00 a.m.Sertraline on 10/12/25 at 8:00 a.m.Tamsulosin on 10/12/25 at 8:00 a.m.Apixaban on 10/12/25 at 8:00 a.m.Carvedilol on 10/12/25 at 8:00 a.m. Gabapentin on 10/12/25 at 8:00 a.m. and 2:00 p.m.The ordered doses of Resident #5's Allopurinol, Bumetanide, Potassium chloride, Prednisone, Sertraline, Tamsulosin, Apixaban, Carvedilol and Gabapentin were on facility's list of medications continuously available at the facility, which revealed they could have been administered on 10/12/25 as ordered by the physician.Review of the nursing progress notes from 10/12/25 did not reveal notification to the physician of the medications that were not administered.III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 11/18/25 at 11:55 a.m. LPN #1 said the hospital usually forwarded the physician's orders to the facility prior to a resident's arrival. LPN #1 said when residents were admitted to the facility, the provider should be contacted to verify the orders. LPN #1 said the orders were then entered in the electronic medical record (EMR) and communicated to the pharmacy. LPN #1 said when medications did not arrive from the pharmacy by the scheduled time for administration, the medications could sometimes be obtained from the automated dispensing machine. Registered nurse (RN) #1 was interviewed on 11/18/25 at 12:15 p.m. RN #1 said when an antibiotic or other medications were not available to give at the time they were ordered for administration she would notify the physician and the physician would provide guidance for how to proceed. The pharmacist was interviewed on 11/18/25 at 1:22 p.m. The pharmacist said medications were delivered to the facility twice daily. She said if medications were ordered later in the day, they might not be delivered until the next day. The pharmacist said if the IV antibiotic could not be given on the start date, she would ideally expect the physician to be notified. The medical director (MD) was interviewed on 11/18/25 at 1:30 p.m. The MD said he expected nurses to use critical thinking skills to determine if a physician should be notified regarding a missed medication dose. The MD said if an IV antibiotic was scheduled early in the day and did not arrive later in the day from the pharmacy, the nurse should call to determine if the antibiotic should be given upon arrival. The MD said he would expect to have a conversation with the nurse if an IV antibiotic could not be given as scheduled.The DON was interviewed on 11/18/25 at 3:07 p.m. The DON said an antibiotic order might need to be extended if the first dose was not able to be administered as scheduled. The DON said she would contact the physician if an antibiotic were not able to be administered as scheduled. The pharmacist was interviewed on 11/18/25 at 3:52 p.m. The pharmacist said all of Resident #5's medications, including the IV Ceftriaxone were delivered to the facility on [DATE] at 3:30 p.m. The pharmacist said she would not expect there to be a delay in administration of an ordered IV antibiotic (such as the Ceftriaxone) once it was received by the facility.-However, the Ceftriaxone was not administered on 10/12/25 after receipt from the pharmacy (see record review above).The director of nursing (DON) and regional nurse consultant were interviewed together on 11/19/25 at 11:08 a.m. The DON said if medications could not be administered because they had not been delivered, the nurse could look in the automated dispensing system to determine if the medication was available at the facility for administration. The regional nurse consultant said the Ceftriaxone should have been administered on 10/12/25 upon delivery from the pharmacy, and not delayed until 10/13/25.LPN #2 was interviewed on 11/19/25 at 12:10 p.m. LPN #2 said if a medication was not available from the pharmacy, she would check the automated medication dispensing system to see if the medication was at the facility for administration. LPN #2 said if she could not administer the medication, she would contact the physician and possibly the pharmacy.The DON and the regional nurse consultant were interviewed again on 11/19/25 at 12:32 p.m. The regional nurse consultant said several of Resident #5's medications were available on 10/12/25 at 8:00 a.m. in the automated dispensing system at the facility and should have been administered to the resident at that time. The regional nurse consultant said there could be delayed healing or increased infection if multiple doses of antibiotics were missed.The DON said the facility was going to be collaborating with the pharmacy to ensure more IV (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antibiotics that were frequently ordered by physicians at admission would be available at the facility to use in the automated medication dispensing system in case the medication did not arrive from the pharmacy in time to be administered. The DON said the facility had provided reeducation to the nursing staff regarding medication availability.V. Facility follow-upThe DON provided a nursing staff education document titled Medication Availability for Admissions on 11/19/25 at 12:32 p.m. The document was dated 11/18/25 (during the survey), and was signed by 10 RN and LPNs. It read in pertinent part, When a medication has been ordered for admission from the discharge paperwork provided from a discharging facility, it is imperative that the patient begins their medications appropriately as ordered. If medications have not arrived from the pharmacy in time for the first dose, there are a couple of options available to pursue: check Nexsys to see if it is available, ask the family if they can bring in the medication from home, contact the pharmacy to request the medication and contact the ADON (assistant director of nursing) or DON for guidance. If the medication is not available, documentation is required, for example, what was done about it and who was contacted.