STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide reasonable accommodation necessary to accommodate mobility and accessibility in the residents' environment for two (#119 and #120) of seven residents reviewed out of 43 sample residents. Specifically, the facility failed to ensure Resident #119 and Resident #120's call lights were within reach when the residents were in bed. Findings include: I. Facility policy and procedure The Call Light/Bell policy and procedure, revised January 2025, was received from the director of nursing (DON) on 6/5/25 at 3:15 p.m. It read in pertinent part, It is the policy of this facility to provide the resident with a means of communication with nursing staff and ensure the safety of residents. Leave the resident comfortable and safe. Place the call device within the resident's reach before leaving the room. II. Resident #119 A. Resident status Resident #119, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included metabolic encephalopathy (a brain disorder that occurs when problems with the body's metabolism lead to brain dysfunction), osteoarthritis, dementia and unsteadiness on feet. The 5/19/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of five out of 15. The resident required substantial to maximal assistance for most activities of daily living (ADL). B. Resident interview and observations (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
	065100	A. Building B. Wing	06/05/2025

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #119 was interviewed on 6/2/25 at 2:09 p.m. Resident #119 said her call light was far away from her bed. Resident #119 said there had been a few instances in which she had her roommate use her call light to get assistance from the nursing staff, as Resident #119 had not been able to reach her call light. Resident #119 said she had spoken with the facility staff about her call light being too far away from her bed but did not want to make a fuss. Resident #119 was sitting in her wheelchair, her call light was plugged into a call light receptacle on the wall approximately four feet away from the left side of her bed. On 6/3/25 at 10:19 a.m. Resident #119 was lying in her bed and her call light was on the floor under a chair, approximately three feet away from the resident. Resident #119 said she could not reach her call light. Certified nurse aide (CNA) #2 entered Resident #119's room and removed the resident's breakfast from her over-bed table. -CNA #2 did not move Resident #119's call light so it was within the resident's reach. On 6/4/25 at 9:21 a.m. Resident #119 was lying in bed. Resident #119's call light was clipped to the top of her bed above her head. Resident #119's call light cord was stretched out from the wall completely without any slack. C. Record review The ADL care plan, revised 2/19/25, revealed Resident #119 had ADL performance deficits due to weakness and arthritis. The care plan documented Resident #119 required one to two staff members to assist with toilet use, transfers, bed mobility, bathing and eating. The pressure ulcer care plan, revised 2/19/25, revealed Resident #119 was at risk for pressure ulcer development. Pertinent interventions included keeping Resident #119's call light within reach. III. Resident #120 A. Resident status Resident #120, age [AGE], was admitted on [DATE]. According to the June 2025 CPO, diagnoses included cerebral infarction (stroke), repeated falls, muscle wasting and fracture of the right femur (thigh). The 5/19/25 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of eight out of 15. The resident required substantial to maximal assistance for most ADL. B. Resident interview and observations Resident #120 was interviewed on 6/4/25 at 1:12 p.m. Resident #120 said he often had a hard time reaching his call light. Resident #120 said he had told his nurse about not being able to reach his call light, and the nurse told him she was working with maintenance to get another call light cord. Resident #120 was lying in bed with his call light cord clipped to the top of his bed with over a foot of space between the resident's head and the call light. Resident #120's call light was plugged into a receptacle directly behind the resident's bed. Resident #120 attempted to reach for his call light but could not grasp it. (continued on next page)

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	065100	A. Building B. Wing	06/05/2025

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 9:18 a.m. Resident #120 was lying in bed with his call light cord clipped to his bed underneath his pillow. C. Record review The ADL care plan, revised 3/4/25, revealed Resident #119 had ADL performance deficits due to weakness, stroke and right hip fracture. The care plan documented Resident #119 required one to two staff members to assist with toilet use, transfers, bed mobility, bathing and eating. The pressure ulcer care plan, revised 3/4/25, revealed Resident #120 was at risk for pressure ulcer development. Pertinent interventions included keeping Resident #120's call light within reach. IV. Staff interviews CNA #2 was interviewed on 6/4/25 at 4:15 p.m. CNA #2 said she clipped the residents' call light cords to their beds so if they had mobility issues they could easily reach them. CNA #2 said Resident #119's call light cord was not long enough to clip to her bed, so she laid it across her over-bed tray and placed the resident's belongings on the cord so it would not fall off. CNA #3 was interviewed on 6/5/25 at 9:42 a.m. CNA #3 said Resident #119's call light was placed on her side table so she could see it. CNA #3 said Resident #119 was able to reach her call light and use it when it was on her side table. CNA #3 said Resident #120 was able to reach his call light when it was placed behind him. CNA #3 said Resident #120's call light was placed behind him due to the location of his bed. The social services director (SSD) was interviewed on 6/5/25 at 10:53 a.m. The SSD said she had never received any grievances from Resident #119 or Resident #120 regarding call lights. The SSD said she had not heard about any issues with the residents' call light cord lengths, but she would talk to Resident #120 and Resident #119 and ensure their call lights were long enough and within reach. Licensed practical nurse (LPN) #1 was interviewed on 6/5/25 at 10:58 a.m. LPN #1 said she preferred when the nursing staff clipped residents' call lights to their bed so they could reach them. LPN #1 said Resident #119 could sometimes reach her call light if it was on her side table, but was unable to reach it other times. LPN #1 said Resident #119 preferred to have her call light near her in bed. LPN #1 said Resident #119 needed help with getting out of bed and incontinence care. LPN #1 said Resident #119 never mentioned to her that her call light cord was too short. LPN #1 said Resident #120 could reach and use his call light when it was positioned above his head. -However, observations Revealed Resident #120 was unable to reach his call light when it was clipped to the bed sheets above his head (see observations above). LPN #1 said Resident #120 used his call light to get help with getting out of bed or when he needed tissues. LPN #1 said Resident #120 occasionally lost his call light cord under his blanket or behind his bed. (continued on next page)

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	065100	A. Building B. Wing	06/05/2025

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 6/5/25 at 11:53 a.m. The DON said when residents were in bed their call light should be within reach by being clipped on their bed, pillow or gown. The DON said she had not heard about any issues with Resident #119 or Resident #120's call light cord length but would look into the issue.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were free from chemical restraints for one (#122) of five residents out of 43 sample residents. Specifically, the facility failed to ensure Resident #122, who was on antipsychotic medication, received appropriate monitoring to ensure signs and symptoms of tardive dyskinesia (involuntary movements) did not worsen. Findings include: I. Professional reference According to the National Institute of Health (NIH) National Library of Medicine's Impact of A Pharmacist-Driven Tardive Dyskinesia Screening Process (7/16/21), retrieved on 6/10/25 from https://pmc.ncbi.nlm.nih.gov/articles/PMC8287863/#s1, According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), tardive dyskinesia (TD) is defined as involuntary movements generally of the tongue, lower face, jaw, torso, and extremities that are developed from the use of antipsychotics. These movements can either be choreiform (rapid and jerky) or athetoid (slow, snakelike, and writhing). Tardive dyskinesia (TD) is defined as involuntary movements that can develop with prolonged antipsychotic use. Several studies have investigated risk factors that may be associated with tardive dyskinesia, including age, sex, and long-term antipsychotic use. II. Facility policy and procedure The Chemical Restraints and Psychotropic Medication Management policy and procedure, revised April 2025, was provided by the director of nursing (DON) on 6/5/25 at 3:51 p.m. It read in pertinent part, The licensed nurse shall review the classification of the drug, the appropriateness of the diagnosis, its indication, behavior monitors, and related side effects prior to verification of admission orders with the attending physician. The facility's interdisciplinary team (IDT) will review to ensure monitoring for adverse consequences and effectiveness of medications are in place. Tardive dyskinesia is abnormal, recurrent, involuntary movements that may be irreversible and typically present as lateral movements of the tongue or jaw, tongue thrusting, chewing, frequent blinking, brow arching, grimacing, and lip smacking, although the trunk or other parts of the body may also be affected. III. Resident #122 A. Resident status (continued on next page)

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	065100	A. Building B. Wing	06/05/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #122, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician order (CPO), diagnoses included schizoaffective disorder (a mental health condition characterized by a combination of symptoms of schizophrenia - a disconnection from reality and a mood disorder like depression or mania), bipolar disorder, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, chronic kidney disease and wandering. The 4/10/25 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) assessment was not conducted because the resident was rarely or never understood. According to the staff assessment for mental status, the resident had short and long-term memory problems and her cognitive skills for daily decision making were severely impaired. She required partial assistance with showering, dressing and personal hygiene. The MDS assessment revealed the resident had received antipsychotic medications during the seven day assessment look back period. B. Observations On 6/2/25, during a continuous observation beginning at 10:25 a.m. and ending at 11:44 a.m., the following was observed: At 10:43 a.m. Resident #122 was walking throughout the common area of the secured unit. Resident #122 was observed constantly smacking her lips together while she walked around. At 11:25 a.m. Resident #122 was still in the common area and continued constantly smacking her lips together. On 6/3/25, during a continuous observation beginning at 10:06 a.m. and ending at 12:23 p.m., the following was observed: From 10:31 a.m. to 11:40 a.m, Resident #122 walked from different chairs in the common area to the women's hallway. From 11:40 a.m. to 12:23 p.m., Resident #122 was observed in the main dining room in the secured unit. Resident #122 was observed constantly smacking her lips together at 10:06 a.m., at 10:59 a.m., and at 11:47 a.m. On 6/4/25, during a continuous observation beginning at 11:14 a.m. and ending at 1:15 p.m., the following was observed: At 11:14 a.m. Resident #122 was sitting in a chair in the common area. The resident was observed constantly smacking her lips together. At 12:30 p.m. Resident #122 was sitting in a chair closest to the television. The resident was observed constantly smacking her lips together. C. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	06/05/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The antipsychotic medication care plan, initiated and revised on 4/5/25, revealed Resident #122 received an antipsychotic medication. Interventions included documenting episodes of behavior, documenting non-pharmacological interventions, documenting side effects, including tardive dyskinesia, completing an Abnormal Involuntary Movement Scale (AIMS) assessment quarterly and monitoring episodes of physical and verbal aggression. The 4/4/25 AIMS assessment documented the resident had a low risk of movement disorder. The assessment revealed the resident had no facial and oral movements, no extremity movements, no trunk (neck, shoulder, and hip) movements and no severity of abnormal movement and no incapacitation due to abnormal movements. -However, according to staff interviews, Resident #122 had been exhibiting signs of tardive dyskinesia since her admission to the facility on 4/4/25 (see interviews below). Review of Resident #122's June 2025 CPO revealed the following physician's orders related to antipsychotic medications: Olanzapine 10 milligrams (mg). Give one tablet at bedtime for behavior, ordered 4/4/25 and discontinued 5/16/25. Olanzapine 7.5 mg. Give 7.5 mg by mouth at bedtime related to schizoaffective disorder, ordered 5/16/25. Quetiapine fumarate 25 mg. Give one tablet in the afternoon for behavior, ordered 4/4/25. Quetiapine fumarate 300 mg. Give two tablets by mouth at bedtime for schizoaffective disorder, ordered 4/5/25. Monitor episodes of side effects: drowsiness, dry mouth, blurred vision, constipation, less common side effects: edema, extra pyramidal symptoms, urinary retention, stiff or tight muscles, restlessness, rare side effects: tardive dyskinesia, ordered 4/4/25. Monitor episodes: physical and verbal aggression, side effects: drowsiness, dry mouth, blurred vision, constipation, less common side effects: edema, extra pyramidal symptoms, urinary retention, stiff or tight muscles, restlessness, rare side effects: tardive dyskinesia, ordered 4/5/25. Review of Resident #122's April 2025, May 2025 and June 2025 medication administration records (MAR) and treatment administration records (TAR), from 4/5/25 through 6/4/25, revealed there was no documentation to indicate the resident was exhibiting symptoms of tardive dyskinesia on 4/6/25, 4/825 through 4/12/25, 4/17/25 through 4/30/25 and 5/1/25 through 6/4/25. -However, according to staff interviews, Resident #122 had been exhibiting signs of tardive dyskinesia since her admission to the facility on 4/4/25 (see interviews below). The 5/21/25 physician's note revealed Resident #122 was seen by the physician for paranoid schizophrenia. The note indicated the resident continued on a gradual dose reduction (GDR) process of her psychotropic medications over time. The resident continued on two antipsychotic medications and the plan was to continue the GDR process. The most recent GDR was done five days prior. (continued on next page)

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	065100	A. Building B. Wing	06/05/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of Resident #122's progress notes, from 4/4/25 to 6/4/25, failed to reveal documentation to indicate the resident was exhibiting symptoms of tardive dyskinesia or that the physician was notified if the resident was exhibiting symptoms of tardive dyskinesia. -However, according to staff interviews, Resident #122 had been exhibiting signs of tardive dyskinesia since her admission to the facility on 4/4/25 (see interviews below). -A review of Resident #122's electronic medical record (EMR) did not reveal any documentation to indicate the resident was being seen by a psychiatric or behavioral health consultant related to her diagnosis or her tardive dyskinesia. IV. Staff interviews Registered nurse (RN) #2 was interviewed on 6/4/25 at 3:57 p.m. RN #2 said he was familiar with Resident #122. He said when a resident had a side effect from a psychotropic medication, he documented the side effect in the resident's TAR. He said Resident #122 smacked her lips because she had tardive dyskinesia. He said she had had symptoms of tardive dyskinesia since she was admitted . Licensed practical nurse (LPN) #2 was interviewed on 6/5/25 at 10:42 a.m. LPN #2 said an AIMS assessment was completed quarterly or every six months when a resident was on antipsychotic medications. He said he documented if a side effect from a psychotropic medication was observed in the MAR and TAR in the resident's chart. He said he was familiar with Resident #122. During the interview, Resident #122 walked into the secured unit, and she was observed to be constantly smacking her lips together. LPN #2 said her behavior of lip smacking was a symptom of tardive dyskinesia. The DON was interviewed on 6/5/25 at 1:30 p.m. The DON said AIMS assessments should be completed every six months or once a quarter for residents on antipsychotic medications. The DON said it was the responsibility of nursing staff to complete the assessments. She said once an antipsychotic medication's side effect was identified, it should be discussed and addressed with the physician or the psychiatrist and documented in the resident's medical record. The DON said it was important to monitor for side effects of psychotropic medications because the side effects could get worse and could affect the resident's quality of life. The DON said she was familiar with Resident #122. She said the resident had had symptoms of tardive dyskinesia since she was admitted to the facility. She said she did not know if there was a referral made to psychiatry for Resident #122 or if the resident's physician had noticed the tardive dyskinesia. The DON said she could not diagnose what caused the tardive dyskinesia. The DON said Resident #122 was on two antipsychotic medications so that could have caused the resident's tardive dyskinesia. (continued on next page)

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	065100	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services director (SSD) was interviewed on 6/5/25 at 2:10 p.m. The SSD said she was familiar with Resident #122. She said the resident had been seen by an outside psychiatrist since she was admitted to the facility. The SSD said she had not received the psychiatrist's records regarding the visits with Resident #122. The SSD said she had noticed the resident's tardive dyskinesia since she was initially admitted . She said when she saw a side effect, such as tardive dyskinesia, she told the psychiatrist or the resident's physician. The SSD said she did not tell Resident #122's physician or psychiatrist. V. Facility follow-up The DON provided psychiatry progress notes for Resident #122 via email on 6/6/25 at 1:44 p.m., after the survey exit. The notes revealed Resident #122 was seen by the psychiatrist on 4/14/25, following her 4/4/25 admission to the facility. The 4/14/25 psychiatry progress notes revealed documentation that the resident's psychomotor activity was normal, there were no abnormal movements observed, there was no psychomotor retardation and there was no psychomotor agitation. -However, the nursing staff identified Resident #122 had tardive dyskinesia and failed to report the side effects to the physician (see interviews above).

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	065100	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#53) of five residents out of 43 sample residents were provided services that met professional standards of quality. Specifically, the facility failed to ensure the physician's orders for Resident #53 contained the appropriate dose of the medication that was to be administered to the resident. Findings include: I. Professional reference According to the National Institutes of Health (NIH), National Library of Medicine, Nursing Rights of Medication Administration (September 2023), retrieved on 6/11/25 from https://www.ncbi.nlm.nih.gov/books/NBK560654/, It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. Incorrect dosage is a prevalent modality of medication administration error. This error type stems from nurses giving a patient an incorrect dose of medications, even if it is the correct medication and the patient's identity is verified, without first checking to ensure it is the correct strength for the patient. According to the NIH, National Library of Medicine, hydrocortisone cream 1% cream (May 2025), retrieved on 6/11/25 from https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=9987165c-1a0f-dd57-e053-2a95a90ae735, Apply to the affected area not more than three to four times a day. According to the NIH, National Library of Medicine, miconazole nitrate 2% cream, (June 2024), retrieved on 6/11/25 from https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=e66191a6-0c3c-7319-e053-2a95a90aae84, Clean the affected area and dry thoroughly. Apply a thin layer of the product over the affected area twice daily (morning and night) or as directed by a healthcare professional. II. Facility policy and procedure The Medication Administration policy and procedure, revised 10/1/23, was provided by the director of nursing (DON) on 6/5/25 at 3:51 p.m. It read in pertinent part, Five rights: right resident, right drug, right dosage, right route, right time are applied for each medication being administered. III. Resident #53 A. Resident status Resident #53, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician order (CPO), diagnoses included vascular dementia, hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction affecting the left non dominant side, type 2 diabetes mellitus and mesothelioma (a rare and aggressive cancer that develops in the lining of certain tissues). (continued on next page)

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	065100	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/24/25 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) assessment was not conducted because the resident was rarely or never understood. According to the staff assessment for mental status, the resident had short and long-term memory problems and his cognitive skills for daily decision making were severely impaired. He was dependent on staff assistance for eating, oral hygiene, toileting, showering, dressing and personal hygiene. The MDS assessment revealed the resident received applications of ointments and medications other than to his feet. B. Observation On 6/4/25 at 1:00 p.m. Resident #53 was sitting in his Broda chair in the hallway next to his room. His abdomen was exposed and there were multiple red spots across his abdomen. C. Record review Review of the June 2025 CPO revealed Resident #53 had the following physician's order: Wound care: Rash to the body. Mix prednisone cream and antifungal cream and apply every shift to the affected body area until resolved. Every shift for rash, ordered 5/19/25. -The physician's order did not include a dose or measurement to direct the nursing staff how much cream to apply to the affected areas with each administration of the medicated treatment. IV. Staff interviews The hospice registered nurse (HRN) was interviewed on 6/3/25 at 3:18 p.m. The HRN said Resident #53 had had skin issues the last couple of months. She said he had a rash on his trunk, his back, his arm and in his arm pits. She said the rash was due to heat. She said when the resident was hot and sweated, the rash was worse. She said the facility recently changed the resident's skin treatment plan. She reviewed the physician's order and she said the order was confusing because she said she did not know how much antifungal cream and how much steroid cream to put on the affected areas. She said if she was the nurse providing the skin care, she would call the physician to clarify how much to use of each cream. Registered nurse (RN) #2 was interviewed on 6/4/25 at 3:57 p.m. RN #2 said he was familiar with Resident #53. He said he provided skin care for the resident's rash today (6/4/25). During the interview, RN #2 went to the treatment cart and displayed the two creams he applied to Resident #53' affected areas. The two creams RN #2 displayed were hydrocortisone cream 1% cream (steroid cream) and miconazole nitrate 2% cream (antifungal cream). He said he measured 4 centimeters (cm) of each cream and mixed the cream in a plastic cup (approximately one ounce) before he applied the cream to the resident's affected areas. He said Resident #53 had a rash on his hands, his chest, his stomach and on his back. He said he determined to use four cm of each cream based on his nursing judgement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #2 was interviewed on 6/5/25 at 10:52 a.m. LPN #2 said he was familiar with Resident #53. He said he provided skin care for the resident's rash today (6/5/25). He said he applied a thin layer of a steroid cream and a thin layer of antifungal cream to the resident's affected areas. LPN #2 said he used as much as possible of the steroid cream and the antifungal cream to cover the body areas affected. He said the resident had a rash on his whole body but mostly on his upper torso. He said the facility tried everything from ointments, to creams to antibiotics, to resolve the resident's rash. LPN #2 said the current plan was to provide the resident with a daily shower, apply the two creams, keep him as dry as possible and provide the skin treatment. He said he determined to use a thin layer of cream based on best nursing practice. The DON was interviewed on 6/5/25 at 1:35 p.m. She said some of the key components of a prescription were the right route, the right resident and the right frequency. She said if the physician left a component out of the prescription, such as the amount to administer, the nurse should contact the physician to clarify the order prior to administering the medication. She said she was not aware Resident #53's prescription creams did not say how much for the nurse to administer. She said the nurses should have clarified how much to use with each administration with the physician.

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	065100	A. Building B. Wing	06/05/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure each resident with limited range of motion received appropriate treatment and services to increase range of motion (ROM) and/or prevent further decrease in ROM for one (#33) of three residents reviewed for restorative services out of 43 sample residents. Specifically, the facility failed to ensure Resident #33's bilateral hand contracture soft splints were applied for contracture management per physician's order. Findings include: I. Facility policy and procedure The Restorative Care Program Overview policy and procedure, revised May 2018, was provided by the director of nursing (DON) on 6/5/25 at 2:30 p.m. It read in pertinent part, Provide direct nursing care services that will maintain optimum physical and mental health for the resident and meet his medical treatment needs. II. Resident #33 A. Resident status Resident #33, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included anoxic brain damage (brain damage caused by a lack of oxygen) and contractures of bilateral upper and lower extremities. The 5/5/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) could not be conducted. He was dependent with bed mobility, transfers, personal hygiene and toileting. The MDS assessment indicated Resident #33 was in a persistent vegetative state with no discernable consciousness. The MDS assessment indicated Resident #33 had received passive ROM and active ROM on six days, with no splint or brace assistance, during the seven day look back assessment period. B. Observations On 6/3/25 at 9:56 a.m. Resident #33 was in his room in bed. His hands were on his chest with all five digits on both hands folded inward toward the palm. He did not have soft splints in his hands. One soft splint was sitting on Resident #33's chest. (continued on next page)

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	065100	A. Building B. Wing	06/05/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 11:16 a.m. Resident #33 was sitting up in his wheelchair. His hands were on his chest with all five digits on both hands folded inward toward the palm. He did not have soft splints in his hands. On 6/4/25 at 10:15 a.m. Resident #33 was in his room in bed. His hands were on his chest with all five digits on both hands folded inward toward the palm. He did not have a soft splint in his hands. On 6/5/25 at 9:20 a.m. Resident #33 was in his room in his wheelchair. His hands were on his chest with all five digits on both hands folded inward toward the palm. He did not have soft splints in his hands. Certified nurse aide (CNA) #1 pulled a soft splint from under the pillow under his head and a second soft splint from the bedside table table and placed both soft splints into Resident #33's hands without difficulty. C. Record review The restorative program care plan, initiated 10/22/24, indicated Resident #33 was immobile and had contractures. Interventions included monitoring/documenting/reporting to the physician signs/symptoms of contractures worsening, nursing rehabilitation program with passive ROM to bilateral upper extremities, providing supportive care with mobility and therapy referral as ordered. -A review of Resident #33's comprehensive care plan did not reveal personalized interventions for checking for the placement of the resident's soft hand splints. The June 2025 CPO revealed a physician's order for Resident #33 to utilize bilateral resting hand splints as tolerated. Check placement for fit and signs of breakdown every shift, ordered 2/15/25. A review of the CNA task documentation, from 5/23/25 to 6/5/25, related to providing passive ROM to Resident #33's hands, wrists, elbow and shoulders and applying hand protectors revealed the following: Fifteen minutes of passive ROM was provided to Resident #33 one time on 5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/25, 6/1/25, 6/3/25, 6/4/25 and 6/5/25. -There was no documentation to indicate whether or not the resident received passive ROM on 5/26/25, 5/27/25 and 6/2/25. -The documentation did not indicate if Resident #33's hand protectors were applied and checked for fit. A facility training inservice sign in sheet, dated 3/20/25, was provided by the assistant director of nursing (ADON) on 6/5/25 at 10:30 a.m. The training provided to staff was for positioning Resident #33 daily with bolsters in between his elbows, applying his hand protectors, conducting skin assessments and getting the resident up on Tuesdays and Thursdays. -However, observations revealed staff did not consistently apply Resident #33's hand protectors (see observations above). III. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 was interviewed on 6/5/25 at 9:18 a.m. CNA #1 said the nursing staff would put Resident #33's soft hand splints in his hands in the morning, if he would let them. She said staff would additionally put bolsters under his elbows. She said sometimes the resident's hands were pretty tight and it was difficult to apply the splints. She said sometimes he was able to maneuver the hand splints out of his hands. She said CNAs would document the application of the splints in the resident's electronic medical record. Registered nurse (RN) #3 was interviewed on 6/5/25 at 9:40 a.m. RN #3 said the facility's restorative nurse aide had recently stepped down from the position and it had been falling onto the CNAs to place splints and provide passive ROM to residents. See said the therapy department had now been overseeing the restorative program. The physical therapist (PT) was interviewed on 6/5/25 at 10:00 a.m. The PT said there currently was not a restorative nurse aide in the facility and they had been slowly transitioning the residents that needed a maintenance restorative program under the domain of the therapy department. He said the therapists had been working with the CNAs on how to place splints and provide passive ROM to residents. The rehabilitation resource was interviewed on 6/5/25 at 11:30 a.m. The rehabilitation resource said Resident #33 had a history of refusing his soft splints to his hands but the facility needed to do a better job of documenting his splints and his refusals on the care plan.

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	065100	A. Building B. Wing	06/05/2025

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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 observations, record review and interviews, the facility failed to ensure that residents were free from significant medication errors for one (#15) of six residents reviewed for medication errors of 43 sample residents. Specifically, the facility failed to ensure that Resident #15 was administered the correct dose of insulin by properly priming the insulin pen before insulin administration Findings include: I. Professional reference According to the Humalog Kwikpen manufacturer guidelines, last updated July 2023, retrieved on 6/12/25 from https://uspl.lilly.com/humalog/humalog.html#ug1 on 6/12/25 included the following recommendations, Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensuring that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select 2 units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with the needle in until it stops, and 0 is seen in the dose window. Hold the dos knob in and count to 5 slowly. You should see insulin at the tip of the needle. II. Resident #15 A. Resident status Resident #15, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2025 computerized physician orders (CPO), the diagnoses included hypertension and diabetes. The 3/12/25 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. She was dependent with toileting, required set up/clean up assistance with eating, supervision with personal hygiene, transfers and was independent with bed mobility. B. Observations On 6/4/25 at 11:15 a.m. licensed practical nurse (LPN) #3 checked Resident #15's insulin order of Humalog 8 units to be administered at the lunchtime meal. She obtained her labeled Humalog insulin pen. She then dialed in two units and pushed on the cartridge. She then placed a disposable needle on the pen and dialed in 8 units into the pen. She then entered Resident #15's room and administered the insulin into the resident's abdomen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN #3 failed to prime the insulin pen prior to administering it to Resident #15. III. Staff interviews LPN #3 was interviewed on 6/4/25 at 11:20 a.m. LPN #3 said the insulin pens could be primed before the needle was placed on the cartridge. She said insulin pens needed to be primed so that the resident would get the correct dose of insulin. -However, according to the manufacturer recommendations the needle needed to be placed on the cartridge prior to priming the insulin pen. The director of nursing (DON) was interviewed on 6/4/25 at 11:23 a.m. The DON said the needle needed to be on the cartridge before it was primed so that the air could be flushed out of the needle and the resident received the correct dose of insulin. She said the insulin did not go anywhere if there was no needle on the syringe. She said she would follow up with LPN #3 and provide education on the correct way to prime the pen.

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	065100	A. Building B. Wing	06/05/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on one of four units. Specifically, the facility failed to: -Ensure housekeeping staff followed the proper cleaning techniques for cleaning resident rooms and disinfecting high frequency touched areas; -Ensure housekeeping staff followed the appropriate procedure when cleaning resident bathrooms; -Ensure housekeeping staff were trained appropriately on housekeeping procedures; -Ensure housekeeping staff performed appropriate hand hygiene; and, -Ensure individual glucometers were cleaned properly. Findings include: I. Housekeeping failures A. Professional reference According to Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection. (July 2021); pages113:104-114, retrieved on 6/10/25 from https://pubmed.ncbi.nlm.nih.gov/33744383/, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control (CDC) Environment Cleaning Procedures (5/4/23) was retrieved on 5/26/25 from https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. (continued on next page)

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	065100	A. Building B. Wing	06/05/2025

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Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Common high-touch surfaces include: -bedrails; -IV (intravenous) poles; -sink handles; -bedside tables; -counters; -edges of privacy curtains; -patient monitoring equipment (keyboards, control panels); -call bells; and, -door knobs. According to the CDC's Hand Hygiene in Healthcare Settings (1/18/21), retrieved on 5/26/25 from https://www.cdc.gov/handhygiene/providers/index.html, Cleaning your hands reduces the spread of potentially deadly germs to patients. Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers. Alcohol-based hand sanitizers are the preferred method for cleaning your hands in most clinical situations. Wash your hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom. When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. B. Facility policy and procedure The Routine and Disinfecting Resident Rooms policy and procedure, revised May 2024, was provided by the nursing home administrator (NHA) on 6/5/25 at 2:30 p.m. It read in pertinent part, It is the policy of the facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cleaning considerations included: dry cleaning procedures will be conducted before wet procedures; clean from areas that are visibly clean and least likely to be contaminated to areas usually visibly dirty; clean from top to bottom (bring dirt from high levels down to the floor levels); and,clean from front to back areas. Consistent surface cleaning and disinfection will be conducted with the detailed focus on high touch areas to include:tToilet flush handles, bed rails, tray tables, call buttons, TV (television) remote, telephones, toilet seats, monitor control panels, touch screens and cables, residence chairs, IV (intravenous) poles, blood pressure cuffs, sinks and faucets, light switches, door knobs and levers. The Hand Hygiene policy and procedure, revised January 2025, was provided by the NHA on 6/5/25 at 2:30 p.m. It read in pertinent part, It is the policy of the facility to clean hands to prevent transmission of possible infectious material and to provide a clean, healthy environment for residents and staff. Hand washing is generally considered the most important single procedure for preventing nosocomial infections. Antiseptics control or kill microorganisms contaminating skin and other superficial tissues and are sometimes composed of the same chemicals that are used for disinfection of inanimate objects. Although antiseptics and other hand washing agents do not sterilize the skin, they can reduce microbial contamination depending on the type and the amount of contamination, the agent used, the presence of residual activity and the hand washing technique followed. C. Observations During a continuous observation on 6/5/25, beginning at 9:53 a.m. and ending at 10:47 a.m., the following was observed: Housekeeper (HK) #1 pushed the cleaning cart to room number #9. She removed the bleach germicidal cleaner from the cart. She sprayed the faucet, the counter, the sink, the ABHR dispenser, the towel dispenser and the trash cans. She placed the spray bottle back onto the cart and removed the broom and swept the room. At 10:02 a.m. she removed a wet rag from the cleaning solution and wiped down the items she had previously sprayed. She removed her gloves and put on clean gloves, without performing hand hygiene. She removed the mop from the mop bucket and placed the wet floor sign in the doorway and mopped the floor. She returned the mop to the mop bucket on the cleaning cart and removed her gloves. room [ROOM NUMBER] and room [ROOM NUMBER] had a shared bathroom and she said she would clean the bathroom when she cleaned room [ROOM NUMBER]. Without performing hand hygiene, she put on clean gloves and pushed the cleaning cart to the housekeeping closet to empty and replace her cleaning solutions including the mop water. -HK #1 failed to disinfect high touch areas such as the bed remotes, the call lights,the light switches, over the bed table and night stand. -HK #1 failed to perform hand hygiene after removing her gloves and putting on new gloves and after exiting the residents' room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	06/05/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:21 a.m HK #1 pushed the cleaning cart to room [ROOM NUMBER] and put on clean gloves, without performing hand hygiene. She removed the disinfectant spray bottle from the cart and sprayed the toilet tank, the grab bars, inside and outside the toilet bowl and emptied the trash. She returned the spray bottle back to the cart and retrieved the toilet bowl cleaner. She poured the toilet cleaner into the toilet, placed the cleaner back on the cart and removed the toilet brush. She scrubbed the inside of the toilet bowl and under the rim. She dipped the toilet brush into the toilet water and scrubbed feces off the bottom of the seat and flushed the toilet. She placed the toilet brush back into its holder and returned it to the cleaning cart. She removed her gloves and put on clean gloves, without performing hand hygiene. At 10:25 a.m. HK #1 removed two wet rags from the cart and used the pink rag to wipe the handrails in the bathroom, the toilet tank, the lid and the inside of the lid. She used a blue rag to wipe the seat, under the seat and the rim. She removed her gloves, used ABHR and put on clean gloves. -HK#1 did not clean the base of the toilet and used the toilet brush outside of the toilet bowl. At 10:27 a.m. HK #1 removed the disinfectant spray from the cart and sprayed the faucet, the sink, the ABHR dispenser and the paper towel dispenser. She placed the spray bottle back onto the cleaning cart, removed a spray bottle with glass cleaner and cleaned the mirror. At 10:30 a.m. HK #1 removed an orange rag from the cart and wiped the ABHR dispenser, the paper towel dispenser, the counter, the faucet and the sink. She placed the soil rag into a bag on the cleaning cart and removed her gloves. She put on clean gloves and placed trash bags into the trash cans. She removed the broom from the cleaning cart and swept the room. She removed her gloves and put on clean gloves. She removed the mop from the mop bucket and mopped the room. She removed her gloves and used ABHR and pushed her cleaning cart to room [ROOM NUMBER]. -HK #1 failed to disinfect high touch areas such as the bed remotes, the call lights, the light switches, over the bed table and night stand. -HK #1 failed to perform hand hygiene after removing her gloves and putting on new gloves. D. Staff interviews HK #1 was interviewed on 6/5/25 at 10:47 a.m. through a translator. HK #1 said she had hand hygiene education when she recently started working at the facility. She said she was supposed to use ABHR or wash her hands after removing gloves and putting on clean gloves. She said prior to working at the facility, she worked at a restaurant and she got into the bad habit of not performing hand hygiene when she changed her gloves. She said high touch areas should be cleaned daily and that she would come back and clean them after cleaning the room at the end of the day. She said she would clean the night stand, bedside table and dresser sometimes when she cleaned the room. She said she did not like touching the resident items when they were not in the room. She said she used the toilet brush on the underside of the seat because there was a small amount of feces on it. She said she did not know she was not supposed to use the toilet brush outside of the toilet bowl. She said she did not document which rooms she needed to come back to to clean high touch areas and just remembered which rooms she needed to come back too. She said she would start cleaning the rooms and the high touch areas at the same time instead of coming back at a later time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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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 - Some	The house keeping and laundry manager (HKM) was interviewed on 6/5/25 at 1:16 p.m. The HKM said hand hygiene education was provided upon hire and was discussed on a regular basis. She said after removing gloves the staff member should always perform hand hygiene before putting clean gloves on. She said the housekeepers should change their gloves after cleaning the bathroom and after cleaning the room. She said the housekeepers should perform hand hygiene when they change their gloves either by washing their hands or using ABHR. She said high touch areas should be cleaned daily when cleaning the room. She said high touch areas included the light switches, call lights, door handles, over bed tables, nightstands, dressers, remotes and handrails. She said the toilet brush should only be used inside the toilet bowl and no other part of the toilet. She said she would immediately provide education to the housekeeping staff and to HK #1 on the correct room cleaning procedure and hand hygiene. The director of nursing (DON) was interviewed on 6/5/25 at 2:36 p.m. The DON said hand hygiene should be performed whenever there was a glove change. She said high touch areas should be cleaned daily and the toilet brush should not be used outside of the toilet bowl. II. Glucometer failures A. Manufacturer guidelines According to Arkray USA, Inc., Arkray Technical Brief cleaning and Disinfecting the Assure Prism multi Blood Glucose Monitoring System (September 2024), retrieved on 6/12/25 from,. https://arkrayusa.com/diabetes-management/professional-healthcare-products/assure/assure-prism-multi/. Each time the cleaning and disinfecting procedure is performed, two wipes are needed; one wipe to clean the meter and a second wipe to disinfect the meter. Wipe the entire surface of the meter using the towelette at least three times vertically and three times horizontally to clean blood and other body fluids from the meter. Repeat the above steps with a new towelette to disinfect the meter. Meter surfaces must remain wet according to contact times listed in the wipe manufacturer's instructions. Once complete, wipe the meter dry. According to the PDI. Sani-Cloth Bleach Germicidal Disposable Wipe instructions (2025). Retrieved on 6/12/25 from https://pdihc.com/products/envhttps://pdihc.com/products/environment-of-care/sani-cloth-bleach-germicidal-disposable-wipe/ironment-of-care/sani-cloth-bleach-germicidal-disposable-wipe/. Although efficacy at one minute contact time for HIV (AIDS virus) and HCV (hepatitis C virus) has shown to be adequate, this time is not sufficient for all organisms listed on this label. Therefore a four minute wet contact time must be used for tuberculosis (TB) and pathogenic fungi. Effective against 52 microorganisms in four minutes. B. Observations (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/25 at 8:35 a.m. registered nurse (RN) #2 removed Resident #122's designated glucometer from the medication cart. RN #2 approached Resident #122 in the common area and obtained her morning blood glucose. He returned to the medication cart with the glucometer and disposed of the lancet and test strip. He then wiped the glucometer with one Sani Cloth Bleach Germicidal wipes and immediately placed it in the resident's labeled glucometer container and returned it to the medication cart. -However, according to the manufacturer guidelines RN #2 should have used a total of two wipes and allowed the glucometer to remain wet for four minutes total disinfection time (see manufacturer guidelines above). C. Staff interviews RN #2 was interviewed on 6/4/25 at 8:45 a.m. RN #2 said glucometers should be wiped before and after use. He said the glucometer should be allowed to dry for two minutes. -However, according to the manufacturer guidelines, the glucometer should stay wet for four minutes (see manufacturer guidelines above). The clinical nurse resource was interviewed on 6/4/25 at 8:45 a.m. The clinical nurse resource said that glucometers should be cleaned according to manufacturer recommended contact disinfection times and that it should be kept wet for three minutes after use. She said she would provide education to the nurses. The infection preventionist (IP) was interviewed on 6/5/25 at 1:42 p.m. The IP said glucometers should be cleaned according to the manufacturer recommendations and the recommended contact disinfection times.