STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065192	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation and Nursing Center of the Rockies	1020 Patton St Fort Collins, CO 80524

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure one (#2) of three residents out of nine sample residents received adequate supervision to prevent accidents. Specifically, the facility failed to ensure identified person-centered fall interventions, which were care planned, were implemented consistently for Resident #2 following a fall with a left wrist fracture. Findings include: I. Facility policy and procedure The Fall Management System policy policy, dated 11/2023, was provided by the director of nursing (DON) on 5/1/24 at 11:26 a.m. It read in pertinent part, It is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls. Care plan interventions will be developed to prevent falls. II. Resident #2 status Resident #2, age under 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included paraplegia, contractures to ankles, pressure ulcer and type I diabetes mellitus. The 4/14/24 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required substantial/maximal assistance with transfers. The assessment indicated the resident did not have a history of falls. A. Resident interview (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was interviewed on 4/30/24 at 4:28 p.m. Resident #2 said she fell a few weeks prior. She said she had been in bed, was reaching for something and fell out of the bed. She said she did not ask for help from the facility staff. She said she had fractured her wrist. B. Observations On 4/30/24 at 4:45 p.m., Resident #2 was lying in bed. There was an air mattress on the bed with no bolsters (foam raised edges) present. A fall mat was in front of the dresser, across the room, and not beside the bed. -Resident #2 said she did not know where her reacher was. The reacher was observed in the wheelchair, behind the bed, out of reach of the resident. On 5/1/24 at 9:13 a.m. Resident #2 was lying in bed. There were no bolsters on the air mattress and the fall mat was across the room in front of the dresser and not beside the bed. At 9:58 a.m., the resident continued to lie in bed. Certified nurse aide (CNA) #1 was interviewed and confirmed the fall mat was in front of the dresser and not in front of the bed. He said he would move it to its proper location. He confirmed there were no bolsters on the mattress. At 10:10 a.m. Resident #2 was laying in bed and the fall mat was beside the bed. -There were no bolsters on the mattress. At 3:30 p.m. the resident was laying in bed, the fall mat was beside the bed and the bolsters were now present on the mattress. C. Record review The admission fall risk assessment for Resident #2, dated 4/8/24, indicated she was at a medium fall risk. A progress note, dated 4/15/24, documented Resident #2 had a fall on 4/13/24 when she was reaching for the bed controls. It documented the resident sustained a contusion to the midline of the forehead and complained of pain to the left forearm. An x-ray, dated 4/14/24, revealed the resident sustained a fracture of the left wrist. The fall intervention implemented was to provide the resident with a reacher. The post-fall interview with Resident #2, dated 4/15/24, documented staff offered the resident a bolster to the air mattress and a fall mat next to the bed. It indicated that the resident was agreeable to the new interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The fall care plan, initiated 4/8/24 and revised 4/15/24, identified Resident #2 had an actual fall. It indicated Resident #2 was at risk for falls. The interventions, updated on 4/14/24 and 4/15/24, included providing bolsters on the air mattress, providing a floor mat beside the bed, providing a reacher to the resident and rearranging the resident's room for better ergonomics and resident preference. III. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 5/1/24 at 9:58 a.m. CNA #1 said he provided care for Resident #2 on a regular basis. He said he did not know the meaning of the falling star sticker that was placed on the name plate outside of the resident ' s room. He said Resident #2 had sustained a recent fall but he was not aware of any fall interventions for the resident. CNA #1 observed the fall mat in front of the dresser. He said he did not know the fall mat needed to be by the bed. He said the resident did not have any bolsters on the mattress. Registered nurse (RN) #1 was interviewed on 5/1/24 at 10:10 a.m. RN #1 said the falling star program was an awareness program for residents who were at risk for falls. She said Resident #2 was at risk for falls. She said it was everyone's responsibility to ensure the fall risk interventions were in place. RN #1 said fall mats should be placed next to the bedside. She said she could not recall where the fall mats were when she went into Resident #2' room that morning when she administered the resident' medications. RN #1 said the current mattress Resident #2 was using did not have bolsters, which was identified as an intervention in the resident ' s comprehensive care plan. She said the bolsters should be on the mattress. She said the reacher should be within reach of the resident. The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed together on 5/1/24 at 2:15 p.m. The ADON said the interdisciplinary team (IDT) reviewed all falls. The ADON said all interventions were discussed during the IDT meeting, documented in the comprehensive care plan and put into place following the meeting. The DON said the falling star sticker indicated a particular resident was considered a high fall risk. She said it was an internal system and was not part of the facility policy. Both the DON and the ADON said they did not check to ensure Resident #2's interventions were put into place following the IDT meeting. The ADON said the facility did not follow through on Resident #2's fall interventions to ensure they were in place.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on record review and interviews, the facility failed to manage the pain of two (#7 and #8) of three residents out of nine sample residents in a manner consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Specifically, the facility failed to ensure pain medication had documented parameters for Resident #7 and Resident #8. Findings include: I. Professional reference The American Medical Directors Association (AMDA) The Society for Post-Acute and Long-Term Care Medicine Pain in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline.[NAME], MD (2021), retrieved on 5/8/24 from www.paltc.org, read in pertinent part, When several options for administering analgesics are ordered for a patient, nursing staff need adequately detailed guidance concerning how and when to select a PRN medication from among the several options that have been ordered. II. Facility policy and procedure The Pain Recognition and Management policy and procedure, dated 12/2023, was provided by the director of nursing (DON) on 5/1/24 at 3:50 p.m. It read in pertinent part, It is the policy of this facility that pain management is provided to residents who require such services, consistent with professional standards of practice. III. Resident #7 A. Resident status Resident #7, age 69, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included left sided-paralysis (hemiplegia) and left sided weakness (hemiparesis) following a stroke (cerebral infarction), contracture of muscle in left upper arm, pain in joints of left ankle and left foot and arthritis of many joints (polyosteoarthritis). The 4/25/24 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. It indicated that the resident was on a scheduled pain regimen and received as needed pain medication. The assessment revealed the resident had frequent pain which frequently interfered with daily activities. B. Resident interview Resident # 7 was interviewed on 5/1/24 at 1:45 p.m. Resident #7 said he had pain in his left foot, left elbow and shoulder. He said it was a stabbing pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7 said he received both Tylenol and Norco pain medications on an as needed (PRN) basis. He said when he received the PRN Tylenol it did not address his pain effectively. He said he lost sleep at night due to the pain. C. Record review The April 2024 CPO documented the following physician orders: Acetaminophen (Tylenol) 325 mg (milligrams) two tablets every six hours as needed for general discomfort/pain/fever, not to exceed 3 gm (grams) from all sources, ordered on 2/13/24. Norco (hydrocodone-acetaminophen) 5-325 mg one tablet every eight hours as needed for pain. ordered on 4/16/24. -The physician's orders for the acetaminophen and Norco pain medications did not indicate the pain level parameters for which to administer each of the medications. -The Norco physician's order did not indicate to not exceed 3 gm of Acetaminophen. D. Staff interviews Registered nurse (RN) #1 was interviewed on 5/1/24 at 2:00 p.m. RN #1 said parameters around pain medications were important to have documented on the physician's orders to ensure the resident's pain was adequately addressed. She confirmed Resident #7 had pain in his left foot, elbow and shoulder. She confirmed that Resident #7's pain medications (Tylenol and Norco) did not have parameters for when to administer the medications. IV. Resident #8 A. Resident status Resident #8, age under 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and chronic post-traumatic headache. The 3/7/24 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. The assessment revealed the resident had frequent pain which interfered with daily activities. B. Record review The April 2024 CPO documented the following physician order: Norco (hydrocodone-acetaminophen) 5-325 mg one tablet every eight hours as needed for oral pain, ordered on 5/18/23. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tylenol 325 MG (acetaminophen) 650 mg by mouth every six hours as needed for mild pain/fever, do not exceed 3 gm within 24 hours, ordered 12/6/23. -The physician's order for the acetaminophen and Norco pain medications did not indicate the pain level parameters for when to administer each of the medications. -The Norco physician's order did not indicate to not exceed 3 gm of acetaminophen. The March 2024 and April 2024 medication administration record (MAR) listed the pain scale utilized for administration of the PRN Norco as a numerical 1-10 scale. -It did not specify what pain levels on the scale of 1-10 the medication should be administered for. -The MAR did not specify what type of pain scale was utilized for Tylenol or what specific pain levels the medication should be administered for. -According to the March 2024 and April 2024 MAR, Norco had been administered when the resident had a pain level ranging from 2-7. C. Staff interviews Charge nurse (CN) #1 was interviewed on 5/1/24 at 2:00 p.m. CN #1 said Resident #8 was able to ask for pain medications. She said the resident had an order for Norco and Tylenol. She said Resident #8 typically asked for pain medications around 2:00 p.m. She said for mild pain, a pain level of 1 to 5 on a pain scale of 1-10, she would administer Tylenol to the resident. RN#1 was interviewed on 5/1/24 at 3:20 p.m. RN #1 confirmed pain parameters were not indicated on the physician's orders for Resident #8's Tylenol or Norco. She said the pain medications needed to have parameters indicated for what pain levels the medications should be administered for.