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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065192 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/23/2024 |
| NAME OF PROVIDER OR SUPPLIER Rehabilitation and Nursing Center of the Rockies | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160</p> <p>Based on observations, record review and interview, the facility failed to provide assistance with activities of daily living (ADLs) to ensure the highest practicable quality of life for three (#3, #12 and #9) of four residents out of 20 sample residents.</p> <p>Specifically, the facility failed to ensure Resident #3, #12 and #9 received timely person-centered assistance with meal set up and/or eating.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Activity of Daily Living policy, reviewed September 2023, was received from the director of nursing (DON) on 10/23/24 at 11:30 a.m. The policy read in pertinent part, It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities. Residents who are unable to carry out activities of daily living (ADL) will receive necessary services or support from staff to maintain eating, grooming, personal hygiene, communication, oral hygiene, transfers and ambulation. ADLs will be care planned to reflect the residents' specific needs.</p> <p>II. Resident #3</p> <p>A. Resident status</p> <p>Resident #3, age greater than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included dysphagia (difficulty swallowing), Alzheimer's disease with late onset (disease that impacts memory and thinking), dementia with agitation (condition which causes a gradual decline in cognitive abilities) and macular degeneration (disease that causes vision loss).</p> <p>The 10/15/24 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of one out of 15. She required substantial/maximum assistance with eating.</p> <p>B. Observations</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During a continuous observation on 10/21/24, beginning at 5:20 p.m. and ending at 6:13 p.m., the following was observed:</p> <p>Certified nurse aide (CNA) #3 and an unidentified CNA each had three residents who required assistance with eating.</p> <p>At 5:28 p.m. Resident #3 had not received her meal and began to repeatedly hit the table, her chest and her head with her hand.</p> <p>Resident #3 continued to hit the table, her chest and her head until CNA #1 moved the resident to another table at 5:39 p.m. CNA #1 proceeded to stand between Resident #3 and another resident who required assistance with eating. CNA #1 provided eating assistance to Resident #3 while simultaneously providing redirection and occasional assistance to the other resident who required assistance with eating, who kept trying to scoot himself away from the table.</p> <p>During a continuous observation on 10/22/24, beginning at 11:08 a.m. and ending at 12:47 p.m., the following was observed:</p> <p>CNA #6 was seated between Resident #3 and another resident who required assistance with eating.</p> <p>At 11:42 a.m. CNA #6 began to assist the other resident with eating</p> <p>At 11:44 a.m. Resident #3's lunch was delivered to the table and placed out of her reach due to her need for assistance with eating. Resident #3 made a repeated motion of reaching for the food on her plate, which was not within her reach, and then bring her hand to her mouth without any food and suck on her fingers. Resident #3 began to hit the table with her hand in between her attempts to retrieve food off of her plate.</p> <p>-CNA #6 did not attempt to distract Resident #3 from hitting the table or making any attempt to offer the resident a bite of food from her plate.</p> <p>At 12:08 p.m., after assisting the other resident with their entire meal, CNA #6 began to assist Resident #3 with eating her meal (24 minutes after the resident's plate had been served).</p> <p>During a continuous observation on 10/22/24, beginning at 5:03 p.m. and ending at 6:18 p.m., the following was observed:</p> <p>At 5:47 p.m. Resident #3's dinner plate was placed on the table in front of her and out of reach.</p> <p>At 5:49 p.m. Resident #3 began to hit her hand on the table.</p> <p>At 5:50 p.m. another resident who required assistance with eating was served her meal and CNA #3 began to assist her with eating, even though the other resident's food had been served after Resident #3's meal.</p> <p>At 5:54 p.m. Resident #3 was redirected to stop hitting the table.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-CNA #3 did not attempt to assist Resident #3 with eating and continued to only assist the other resident with eating.</p> <p>At 5:55 p.m. CNA #3 began to provide assistance with eating to Resident #3 while continuing to provide eating assistance to the other resident simultaneously.</p> <p>-Resident #3 was not provided with eating assistance until almost ten minutes after her meal was served.</p> <p>C. Record Review</p> <p>The care plan, initiated 10/9/24 and revised 10/16/24, revealed Resident #3 had a nutritional risk related to Alzheimer's and dementia. Pertinent interventions included, providing the resident's diet as ordered by the physician, providing meals in the dining room if the resident was in agreement and providing full staff assistance with meals.</p> <p>III. Resident #12</p> <p>A. Resident status</p> <p>Resident #12, age less than 65, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included cognitive communication deficit.</p> <p>The 8/21/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of one out of 15. She required supervision or touching assistance with eating.</p> <p>B. Observations</p> <p>During a continuous observation on 10/22/24, beginning at 11:08 a.m. and ending at 12:47 p.m., the following was observed:</p> <p>The meal consisted of a piece of chicken with gravy, rice, mixed vegetables, peach cobbler.</p> <p>At 11:40 a.m. Resident #12's meal was served to her. The resident did not make any attempts to begin eating her meal</p> <p>At 12:23 p.m. CNA #4 noticed that Resident #12 had not eaten any food and offered to cut up the resident's chicken for her. After the chicken had been cut up, Resident #12 began to eat lunch, 43 minutes after her meal had initially been served.</p> <p>C. Record Review</p> <p>The care plan, initiated 8/16/24, revealed Resident #12 required set up and clean up assistance with eating. Resident #12 had a weak left arm and required assistance with meals as needed.</p> <p>IV. Staff interviews</p> <p>(continued on next page)</p> |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>CNA #8 was interviewed on 10/23/24 at 11:40 a.m. CNA # 8 said CNAs were supposed to only be assigned two residents at a time that required assistance with eating. CNA #8 said the facility had recently admitted additional residents that required eating assistance and staff had been assigned three or four residents at one time to assist with meals. CNA #8 said she would assist two residents at the beginning of the meal and two more residents at the end of the meal. CNA # 8 said she would sit in between two residents and use both her hands to feed the residents simultaneously. CNA #8 said it was important to prevent one resident's food from becoming cold while another resident was being assisted.</p> <p>CNA #8 said Resident #3 was dependent on staff and required full assistance with eating during meals. CNA #8 said that Resident #3 usually ate the majority of her meals if she was assisted.</p> <p>CNA #8 said Resident #12 required minimal assistance with eating but needed assistance with cutting up her food so she could eat it herself. CNA #8 said Resident #12 should have had her food cut up by staff when her tray was served. CNA #8 said Resident #12 would become agitated if her hands became dirty or sticky. CNA #8 said Resident #12 had the capability to cut up soft foods but she would not cut them up because of her dislike of having potentially dirty hands. CNA #8 said Resident #12 would not have been unable to cut up a piece of chicken without assistance.</p> <p>CNA #9 was interviewed on 10/23/24 at 11:40 a.m. CNA #9 said CNAs should not be assigned more than two residents at a time to assist with eating. CNA #9 said she would sit in the middle of two residents and use both of her hands to assist the residents with eating so both residents were able to eat at the same time. CNA #9 said the facility admitted more residents that required eating assistance during meals.</p> <p>CNA #9 said Resident #3 required full eating assistance at each meal. CNA #9 said Resident #3 should have been assisted to eat at the same time as the other resident, not after the other resident was finished eating. CNA #9 said any CNA assisting other residents to eat should know that both residents should be assisted at the same time. CNA #9 said there may have been staff brought in to help with assisting the residents with eating who were not aware of the process.</p> <p>CNA #9 said Resident #12 did not require assistance with eating but she did require help to cut up food, such as chicken. CNA #9 said even though Resident #12 was able to cut up some foods, such as a burrito, the resident would not do it for fear of getting her hands messy. CNA #9 said Resident #12's food should be cut up for her at the time the meal was served.</p> <p>The DON, the assistant director of nursing (ADON), the clinical resource nurse (CRN) and registered nurse (RN) #1 were interviewed together on 10/23/24 at 12:01 p.m. The DON said a CNA could only assist two residents with eating at one time. The DON said a CNA needed to be seated while they were providing residents with eating assistance.</p> <p>The ADON said a nurse should be pulled from a medication cart to help with assisting residents with eating if needed.</p> <p>RN #1 said dining tables should be served at the same time so staff could assist the residents at the table with eating at the same time.</p> <p>42838</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>V. Resident #9</p> <p>A. Resident status</p> <p>Resident #9, age 79, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included unspecified dementia, unspecified severity, with other behavioral disturbances.</p> <p>The 8/15/24, minimum data set (MDS) assessment revealed the resident was cognitively impaired based on the staff assessment for mental status. She had poor long term and short term memory. Decision making skills were moderately impaired. She required set up assistance with meals.</p> <p>B. Observations</p> <p>On 10/22/24 during the breakfast meal, the following observations were mad:</p> <p>At 8:16 a.m. Resident #9 was lying in bed and was served her breakfast tray which consisted of a pancake. The pancake was not cut up and the resident was not eating her breakfast.</p> <p>At 8:38 a.m. Resident #9 still had not eaten her meal and had not received any meal assistance from staff.</p> <p>At 10:35 a.m. Resident #9 still lying in bed and her breakfast meal had not been touched.</p> <p>On 10/22/24 during a continuous observation of the lunch meal, beginning at 12:11 p.m. and ending at 1:08 p.m., the following observations were made:</p> <p>At 12:11 p.m. Resident #9 received her lunch meal. She received pork, rice, a blend of vegetables and apple crisp.</p> <p>At 12:22 p.m. Resident #9 was not eating her lunch and she had not received any assistance with eating from staff. She had not touched her meal since it had been served.</p> <p>At 12:39 p.m. Resident #9 had not eaten anything and no staff had checked on or encouraged her to eat.</p> <p>At 12:50 p.m. Resident #9 was picking at her food with her fingers. She ate the vegetables and the whipped cream off the top of the apple crisp, however, no staff had assisted her with eating the other items on her plate.</p> <p>At 1:08 p.m. an unidentified CNA removed Resident #9's food tray. She was not offered any encouragement to eat or another alternative for food. The resident had only consumed approximately 20 percent (%) of her meal.</p> <p>On 10/23/24 during a continuous observation of the breakfast meal, beginning at 8:14 a.m. and ending at 8:43 a.m., the following observations were made:</p> <p>At 8:14 a.m. CNA #10 delivered a breakfast room tray to Resident #9 while she was lying in bed. She was served scrambled eggs, hashbrowns, toast, oatmeal and some potato chips.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>At 8:18 a.m. Resident #9 was awake and was picking at her meal with her fingers.</p> <p>At 8:27 a.m. Resident #9 was still picking at her food with her fingers. She had not received any assistance to eat from staff.</p> <p>At 8:28 a.m. RN #1 went in to Resident #9's room, told the resident she was not eating her oatmeal and the resident responded no. Resident #9 had eaten the eggs but had not touched the hashbrowns or the oatmeal.</p> <p>-RN #1 did not offer Resident #9 an alternative to the oatmeal or offer to assist the resident with eating it.</p> <p>At 8:29 a.m. RN #1 left the resident's room.</p> <p>At 8:40 a.m. Resident #9 still had her toast in her hands. She had not eaten any more of it (half eaten). She had not touched the hashbrowns or the oatmeal. She took the potato chips off of the tray and did not eat them. She had not drunk any of her grape juice.</p> <p>At 8:43 a.m. CNA #8 went into Resident #9's room and removed the meal tray.</p> <p>-CNA #8 did not provide any encouragement to eat to the resident or offer her any substitutes to the meal. Resident #9 had only eaten the eggs and half of her toast.</p> <p>C. Record review</p> <p>The care plan, revised 10/12/23, identified Resident #9 was a nutritional risk due to a dementia diagnosis. Pertinent interventions included a regular diet, including thinned liquids, providing meals in the dining room if the resident was in agreement, offering and encouraging snacks/fluids between meals, offering the resident portable meal options if she was not eating in the dining room and offering soft foods when the resident's dentures were not in use.</p> <p>D. Staff interviews</p> <p>CNA #8 was interviewed on 10/23/24 at 10:15 a.m. CNA #8 said Resident #9 had cognitive impairments. She said the resident was able to feed herself but she required meal set up and encouragement to eat. She said the resident ate much better when she could pick the food up with her fingers. CNA #8 said Resident #9 did not do well eating in the dining room and she liked to eat in bed.</p> <p>RN#1 was interviewed on 10/23/24 at 10:35 a.m. RN # 1 said Resident #9 preferred to eat in her room and was anxious when she was out in the dining room. RN#1 said Resident #9 was able to feed herself but she required encouragement to eat and set up assistance. RN #1 said Resident #9 preferred little bowls and finger foods.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160</p> <p>Based on observation, interview and record review the facility failed to provide adequate supervision during use of assistive devices to keep residents free from safety hazards for two (#10 and #11) of three residents out of 20 sample residents.</p> <p>Specifically, the facility failed to ensure wheelchair pedals were attached to Resident #10's and Resident #11's wheelchairs prior to pushing the residents within the facility.</p> <p>I. Facility policy and procedure</p> <p>The Fall Management System policy, reviewed November 2023, was received from the director of nursing (DON) on 10/22/24 at 4:55 p.m. The policy read in pertinent part, It is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.</p> <p>II. Resident #10</p> <p>A. Resident status</p> <p>Resident #10, age greater than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included cognitive communication deficit, generalized muscle weakness, repeated falls and dementia.</p> <p>The 8/1/24 minimum data set (MDS) assessment revealed the resident had short term and long term memory impairment with moderate impairment in making decisions regarding daily life. The resident had both short and long term memory problems. He required physical assistance with activities of daily living (ADL).</p> <p>B. Observations</p> <p>During a continuous observation on 10/22/24, beginning at 11:08 a.m. and ending at 12:47 p.m., the following was observed:</p> <p>At 11:13 a.m. Resident #10 was pushed into the dining room by an unidentified staff member without foot pedals on his wheelchair which caused the resident to hold his feet up off the floor.</p> <p>At 12:13 p.m. Resident #10 was pushed out of the dining room by an unidentified staff member. The resident's wheelchair did not have foot pedals on it.</p> <p>On 10/23/24 at 11:30 a.m., the physical therapist (PT) was observed asking Resident #10 to lift his feet while he pushed the resident in his wheelchair from the dining room to his room.</p> <p>C. Record review</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The fall risk care plan, initiated 4/25/24 and revised 4/30/24, revealed Resident #10 was at risk for falls related to weakness and impaired mobility. Interventions included encouraging activities and time in the common area for increased supervision, anticipating and meeting the resident's needs and keeping the resident's call light within reach.</p> <p>The fall care plan, 5/6/24 and revised 5/21/24, revealed that Resident #10 had sustained previous falls without injury related to a history of falls, dementia, weakness, lack of safety awareness, and impulsivity. Interventions included placing a call don't fall sign in the resident's room and bright colored tape on the resident's call light.</p> <p>-The care plans did not include an intervention to ensure Resident #10's foot pedals were in place in order to prevent potential falls when the resident was being pushed in his wheelchair.</p> <p>The fall risk assessment dated [DATE] revealed Resident #10 as a high fall risk.</p> <p>III. Resident #11</p> <p>A. Resident status</p> <p>Resident #11, age greater than 65, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included spastic hemiplegia (paralysis or severe loss of strength on one side of the body) affecting the right dominant side, abnormal involuntary movements, generalized muscle weakness, lack of coordination, encephalopathy (brain syndrome that can cause confusion, memory loss, twitching), cognitive communication deficit, and non-traumatic intracranial hemorrhage (a type of stroke that cause blood to pool between the brain and skull preventing oxygen from reaching the brain tissue).</p> <p>The 6/27/24 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of 11 out of 15. The MDS assessment revealed he required minimal assistance with use of a manual wheelchair.</p> <p>B. Observations</p> <p>On 10/22/24 at 11:49 a.m. Resident #11 was assisted to the dining room by an unidentified staff member. The resident did not have foot pedals on his wheelchair which caused the resident to hold his feet up off the floor.</p> <p>On 10/22/24 at 5:39 p.m. Resident #11 was observed being wheeled into the dining room without foot pedals on his wheelchair which caused the resident to have to hold his feet up off the floor.</p> <p>C. Record review</p> <p>The October 2024 Kardex (a tool utilized to provide consistent resident care) revealed Resident #1 was a high fall risk, required frequent rounding and staff was to encourage activities in the common area for increased supervision.</p> <p>IV. Staff Interviews</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The DON was interviewed on 10/23/24 at 1:34 p.m. The DON said some residents refused to have foot pedals on their wheelchairs. The DON said staff education regarding ensuring foot pedals were in place on residents' wheelchairs when they were being pushed was frequently provided in daily huddles on every shift. The DON said the foot pedals could be placed on the chair and then removed once the resident has been transported to the location. She said there was no system in place as to where the foot pedals were kept so they were easily accessible to staff for transportation of residents.</p> <p>The director of rehabilitation (DOR) was interviewed on 10/23/24 at 2:44 p.m. The DOR said wheelchair pedals were kept in a residents' closet if they were not attached to the wheelchair. The DOR said he provided education to residents on an as needed basis about wheelchair foot pedal importance and safety. He said if a resident dropped their feet suddenly to the floor when they were being transported in a wheelchair without foot pedals attached, it could cause the resident to be propelled forward out of the wheelchair and sustain a fall.</p> | | |