| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065291 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rock Creek Rehabilitation and Healthcare Center | 2277 East Dr<br>Monte Vista, CO 81144 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(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 |
|---|---|---|---|
| | 065291 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rock Creek Rehabilitation and Healthcare Center | 2277 East Dr<br>Monte Vista, CO 81144 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards for one (#1) of three residents reviewed for acute changes in condition out of four sample residents.Specifically, the facility failed to timely notify the physician and intervene to treat high blood pressure for Resident #1.Findings include:I. Professional reference The article Hypertensive crisis: What are the symptoms? (2024) was retrieved on [DATE] from https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/expert-answers/hypertensive-crisis/faq-20058491?cjdata=MXxODB8WXww&cjevent=765460d1cfad11f082c907180a1cb829&cm_mmc=CJ-_-100357191-_-5250933-_-Evergreen+Link+for+Mayo+Clinic+Diet&utm_source=cj&utm_content=100357191&utm_capaign=3-months read in pertinent part; A hypertensive crisis is a sudden, severe increase in blood pressure. The blood pressure reading is 180/120 millimeters of mercury (mmHg) or greater. A hypertensive crisis is a medical emergency. It can lead to a heart attack, stroke, or other life-threatening health problems. See emergency medical help for anyone with these blood pressure numbers. Call 911 or emergency medical services if your blood pressure is 180/120 mmHg or greater and you have chest pain, shortness of breath, or symptoms of stroke. Stroke symptoms include:-numbness or tingling;-loss of feeling in the face, arm, or leg;-trouble walking;-trouble speaking; and,-changes in vision.II. Facility policy and procedureThe Change in a Resident's Condition or Status policy, undated, was received from the director of nursing (DON) on [DATE] at 12:10 p.m. It read in pertinent part, Our facility promptly notifies the resident, the physician, and the resident representative of changes in the resident's medical status. The nurse will notify the physician when there has been a(n): -accident or incident involving the resident;-significant change in the resident's physical condition; and/or,-need to transfer the resident to a hospital. A significant change of condition is a major decline in the resident status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. Prior to notifying the physician, the nurse will gather relevant information for the physician, including information prompted by the interactive communication form. The nurse will record in the resident's medical record information relative to changes in the resident's medical status.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on [DATE]. Resident #1 did not return to the facility and expired on [DATE] while in hospice care. According to the [DATE] computerized physician orders (CPO), diagnoses included hypertension, diabetes mellitus and Alzheimer's disease.The [DATE] minimum data set (MDS) assessment revealed Resident #1 was unable to complete the brief interview for mental status (BIMS) assessment. Resident #1 was assessed by staff to be severely impaired in cognition and daily decision-making. The assessment revealed Resident #1 was dependent on staff for all activities of daily living (ADL). Resident #1 did not walk and was dependent on staff for mobility with a manual wheelchair. B. Record reviewResident #1's fall prevention care plan, revised [DATE], revealed Resident #1 was at risk for falls. The pertinent fall prevention interventions included placing a sign for Resident #1 to call for assistance, and placing anti-tipper devices on Resident #1's wheelchair to prevent tipping backwards ([DATE]).A fall occurrence progress note, dated [DATE] at 9:00 a.m., revealed Resident #1 was being pushed in a manual wheelchair to her room. The resident's foot caught on the carpet and she fell out of the wheelchair onto the floor. Resident #1 hit her head and sustained a laceration surrounded by a hematoma (bruising and swelling) to the middle of the upper forehead at her hairline. Resident #1 was unable to follow commands, and the nurse completed passive range of motion for all major joints while Resident #1 was on the floor. Vital signs were normal except for the resident's blood pressure measurement of 190/108 millimeters of mercury (mmHg). Resident #1's statement on what was being attempted when the fall occurred was that her wheelchair did not have a footrest or foot pedals and her feet were dragging on the floor. The evaluation revealed Resident #1's representative, the physician, the DON, and the nursing home administrator (NHA) were notified regarding the fall. The record review revealed there were no new physician's orders given at the time of the initial fall notification.Review of Resident #1's post-fall neurological assessments revealed the following:On [DATE] at 9:00 a.m. the resident had a normal level of consciousness, abnormal speech/aphasia(impaired speech) and no hand grasps. Vital signs: blood pressure 139/106 mmHg, heart rate 90 beats per minute (bpm) and respiration rate was 18 per minute.On [DATE] at 9:15 a.m. the resident had a normal level of consciousness, abnormal speech/aphasia and no hand grasps. Vital signs: blood pressure 190/108 mmHg, heart rate 77 bpm, respirations 18 per |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065291 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rock Creek Rehabilitation and Healthcare Center | 2277 East Dr<br>Monte Vista, CO 81144 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065291 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rock Creek Rehabilitation and Healthcare Center | 2277 East Dr<br>Monte Vista, CO 81144 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of three residents reviewed for accident hazards received adequate supervision out of four sample residents.Resident #1, who was dependent on facility staff for wheelchair mobility, sustained a fall from her wheelchair on [DATE], which resulted in a cervical spine fracture.During the facility's investigation of the fall, it was discovered that staff failed to attach the foot pedals to Resident #1's wheelchair. As a result, Resident #1 was unable to rest her feet on the foot pedals while being transported. On [DATE], while Resident #1 was being transported from the dining room to her room, Resident #1 caught her foot/feet on the rug, fell forward out of the wheelchair, and hit her head on the floor as she fell.Due to the facility's failure to ensure staff used wheelchair safety equipment/foot pedals, Resident #1 sustained a fall on [DATE], which resulted in a cervical (C1) spine fracture. Specifically, the facility failed to ensure staff transported residents in their wheelchairs with the foot pedals in place, which resulted in a fall for Resident #1 where she sustained a C1 spine fracture.Findings include:Record review and interviews confirmed the facility corrected the deficient practice before the onsite investigation on [DATE], resulting in the deficiency being cited as past noncompliance with a correction date of [DATE].I. Incident on [DATE]Resident #1, who was dependent on facility staff for wheelchair mobility, sustained a fall from her wheelchair on [DATE], which resulted in a cervical spine fracture.During the facility's investigation of the fall, it was discovered that staff failed to attach the foot pedals to Resident #1's wheelchair. As a result, Resident #1 was unable to rest her feet on the foot pedals while being transported. On [DATE], while Resident #1 was being transported from the dining room to her room, Resident #1 caught her foot/feet on the rug, fell forward out of the wheelchair, and hit her head on the floor as she fell.Due to the facility's failure to ensure staff used wheelchair safety equipment/foot pedals, Resident #1 sustained a fall on [DATE], which resulted in a cervical (C1) spine fracture. II. Facility plan of correctionA. Immediate action to correct the deficient practice for Resident #1The correction action plan implemented by the facility in response to Resident #1's fall on [DATE] was provided by the director of nursing (DON) on [DATE] at 4:10 p.m. The corrective action plan included documentation that all facility nursing staff were educated on [DATE] on the facility's wheelchair safety procedure and the wheelchair policy and procedure. The education included instructions that all residents who required staff assistance for wheelchair mobility must have foot pedals in place. The corrective action plan identified that the facility ensured an adequate supply of foot pedals was available when needed.B. Systemic changesStaff were educated on [DATE] to ensure residents that required staff assistance for wheelchair mobility were required to have foot pedals on their wheelchairs. Staff were educated foot pedals must be used during transportation. C. MonitoringThe interdisciplinary team (IDT) was responsible for reviewing all fall occurrences and occurrences that involved facility equipment, including wheelchairs. The maintenance inspection and repair logbook documentation, dated [DATE], revealed the facility inspected all manual wheelchairs for damaged or missing components such as, hand grips, brakes, casters, wheels, seats and leg rests. The work history monthly report for [DATE] to [DATE] documented the wheelchair inspections that were completed. III. Facility policy and procedureThe Wheelchair policy and procedure, undated, was provided by the DON on [DATE] at 12:14 p.m. It revealed in pertinent part, To safely push a wheelchair, you must communicate with the user and take special precautions for obstacles like ramps and curbs.Check the equipment. Ensure the wheelchair is in good working order. Check that all parts are securely attached. Footrests significantly enhance safety for older adults in wheelchairs by preventing their feet and legs from draping, which could cause them to catch on the ground, get caught under the wheels, or even get pulled out of the wheelchair entirely. Keeping the feet elevated and supported on the footrests ensures that there is sufficient ground clearance, preventing the footplate from hitting obstacles or catching on the ground, which can cause the wheelchair to tip.IV. Facility Investigation of incident on [DATE]On [DATE], the facility investigated Resident #1's fall. The facility investigation revealed that on [DATE] at 9:00 a.m., while a staff member was transporting Resident #1 in a manual wheelchair, Resident #1 caught her foot on the carpeted floor and fell to the floor. Resident #1 struck her head on the floor and staff observed a laceration and a hematoma (bruising and swelling) on her forehead. Resident #1 had a bruise on her left hand. Resident #1 had a blood pressure reading of 190/108 millimeters of mercury (mmHg). The nurse immediately placed a foot shelf on Resident #1's wheelchair, completed neurocognitive assessments, and notified appropriate parties, including the physician. Resident # 1 was transferred to the |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065291 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rock Creek Rehabilitation and Healthcare Center | 2277 East Dr<br>Monte Vista, CO 81144 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards for one (#1) of three residents reviewed for maintaining resident health records out of four sample residents.Specifically, the facility failed to ensure physicians' progress notes for Resident #1 were available in the electronic medical record (EMR).Findings include:I. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on 6/8/25. According to the June 2025 computerized physician orders (CPO), diagnoses included high blood pressure, diabetes mellitus and Alzheimer's disease.The 5/8/25 minimum data set (MDS) assessment revealed Resident #1 was unable to complete the brief interview for mental status (BIMS) assessment. Resident #1 was assessed by staff to be severely impaired in cognition and daily decision-making. The assessment revealed Resident #1 was dependent on staff for all activities of daily living (ADL). Resident #1 did not walk and was dependent on staff for mobility with a manual wheelchair. B. Record reviewRecord review revealed there were no physician's progress notes in Resident #1's EMR after 1/15/25. As a result, physician's records were unavailable for review during the survey. II. Staff interviewsThe director of nursing (DON) and the nursing home administrator in training were interviewed together on 10/14/25 at 3:15 p.m. The DON said she was unable to locate the physician's progress notes in Resident #1's EMR after 1/15/25. The DON said the previous physician documented in a system separate from the facility's EMR. The DON said that she was able to contact the former physician and request records as needed, and the documents would be available either late evening or on 10/15/25. The DON said the facility obtained physician services from a new provider in July 2025, and the facility had been working with the new provider to ensure documentation was available in residents' EMRs. |