STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065423	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Rock Creek, LLC	4880 Ziegler Rd Fort Collins, CO 80528

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to ensure one (#1) of three residents out of 11 sample residents received treatment and care in accordance with professional standards of practice. Resident #1 was admitted to the facility from the hospital on 6/13/24 where she was diagnosed with hyperkalemia (elevated potassium) due to acute renal failure. There, she was treated for damage to the skin on her right hand and forearm after sodium bicarbonate, which was being administered intravenously (IV), leaked out of the IV into the tissue under the skin of her right hand and forearm. A wound assessment prior to hospital discharge on 6/11/24 documented that the right hand wound had fluid filled blisters with scant areas of drainage. The skin was fragile, with a need for strict continuous evaluation of the affected area until the resident could be seen by a wound care specialist and a plastic surgical specialist. However, the facility failed to ensure the resident's right hand and forearm were continuously evaluated. Record review revealed a hand and arm assessment by nursing on admission 6/13/24, but no further assessments until 7/6/24, when nursing documented the resident's right hand had worsened to reveal an open wound covered in slough (dead tissue that accumulates in a wound, usually appearing as a yellow, white, or tan fibrous material), and a large area of the resident's forearm (22.8 centimeters (cm) in length by 10 cm wide) covered with a layer of thick blackened leathery skin (necrotic tissue). The skin proximal to the knuckles was open measuring 0.5 cm long by 5.8 cm wide with yellow slough. The wound extended from the resident's knuckles up to her mid-forearm. Further record review revealed no notes documented the progressive worsening of the condition of the resident's hand and forearm and the development of black necrotic tissue. In an interview with the wound care nurse (WCN), she stated she had not performed weekly assessments of the resident's right forearm because the wound was not open at the time of the resident's admission; this, however, conflicted with a hospital assessment on 6/11/24 that documented some drainage. In addition, she said she never discussed the status of the wounds on Resident #1's right hand and forearm with the resident's primary care physician (PCP). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Further record review revealed no evidence the resident's PCP was notified of the condition of the resident's skin on 7/6/24 or that the physician had assessed the resident's right hand and forearm before or after 7/6/24, although a note by the PCP on 7/9/24 referenced the resident's right forearm was causing her pain and there was visible drainage leaking through the bandage on her right hand. Treatment orders for the resident's right hand and forearm (start date 6/16/24) were not changed or re-evaluated for appropriateness and effectiveness after the condition of the wounds worsened. In an interview, the PCP confirmed he had not received a report from the floor nurses, the DON, or his physician assistant (PA) on the condition of the resident's right hand and forearm wound and was unaware the wound had worsened and had developed necrotic tissue. On 7/11/24, the resident's daughter contacted emergency medical services, and the resident was transferred to the hospital emergency department (ED) where she was started on antibiotics for a wound infection. She returned to the facility that day, but two days later, on 7/13/24, she became hypotensive (low blood pressure) with fever and shortness of breath. She returned to the hospital and was admitted , per a 7/15/24 hospital treatment note, for sepsis secondary to an infected right forearm wound with tissue necrosis. Treatment involved the removal of the top layer of necrotic skin and subcutaneous tissue (the deepest layer of the skin), as well as the removal of the forearm tendon that allows one to bend the fingers and thumb to grasp an object or make a fist. According to the hospital note, the resident would require long-term IV antibiotic infusions and several skin grafts. In an interview, the facility medical director said that after reviewing the resident's medical record, she found there was no evidence that the wound was being properly assessed or that the changes in the wound condition were being communicated to the proper medical providers. The facility's failure to assess and monitor the resident's right forearm and hand wound after her admission on 6/13/24, failure to document and report changes in the wounds to the resident's PCP for assessment and treatment recommendations, and failure to seek medical treatment for the infected wounds timely, contributed to serious harm for Resident #1 and the potential for further serious resident harm if the facility's system for assessing, monitoring and communicating wound changes was not immediately corrected. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy A review of the investigation from 7/30/24 to 8/1/24 of the resident's wound to the right hand and forearm revealed the resident's wounds worsened and became infected. The resident needed hospital-level care and treatment to treat the infected wounds and remove extensive necrotic tissue and the tendon in the resident's arm. Record review and interviews conducted during the investigation revealed the facility failed to take appropriate steps before and after the floor nurse's documentation on 7/6/24 of the worsening of Resident #1's wounds so that treatments would be implemented to prevent the wound from becoming septic. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Specifically, the facility failed to assess and monitor the resident's wounds after her admission on 6/13/24, failed to document and report changes in the wounds to the resident's PCP for assessment and treatment recommendations, and failed to seek medical treatment for the infected wounds timely, B. Facility notice of immediate jeopardy On 7/31/24 at 3:34 p.m. the nursing home administrator (NHA) and director of nursing (DON) were notified that the facility's failure to identify and respond to the worsening condition of Resident #1's right hand and forearm created an immediate jeopardy situation. C. Facility plan to remove immediate jeopardy On 7/31/24 at 5:00 p.m. the facility submitted a final plan for removal of the immediate jeopardy. The plan read: Plan for removal of Immediate Jeopardy 7/31/2024 The DON, ADON (Assistant DON), and designated licensed nurses will conduct an immediate skin sweep to include evaluation of all skin integrity concerns and including peripheral IV lines. 1. The facility will conduct an immediate skin sweep of all current patients. The sweep will specifically include (but not be limited to) a full assessment of skin integrity and include any/all IV lines (peripheral, midline, etc.). Staff will immediately address any/all newly identified skin related issue(s) if/as indicated. Follow-up will include documentation to reflect any acute finding, notification of patient/responsible party, provider, wound care nurse, DON and include treatment orders and/or intervention(s) and care plan update(s) as indicated. 2. On 7/31/24, the DON, ADON, and designees initiated in-servicing to all nursing staff as to the expectation that any skin anomaly noted should be carefully monitored by the licensed nurse each shift. DON, ADON, wound nurse, or designee will in-service nursing staff each shift until all nursing staff has received education and understanding of policy confirmed. Nursing documentation should reflect the ongoing status of the wound throughout the patient's stay or until resolved. Any concern(s) identified shall be reported to the provider, DON, and wound nurse and the record shall be updated with any resultant change(s) made to the treatment plan (e.g. orders, etc.) The Wound Nurse received additional training from the DON on 7/31/24 to monitor complex non-pressure wounds that can potentially result in an infection. All Nursing staff members will be educated on policy and procedure for skin evaluation and intervention before their next scheduled shift and will provide a return demonstration to ensure competency. This education will be completed by the DON or designee. All patients have the potential to be affected by this alleged deficiency. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Administrator or designee will monitor for compliance of the wound process including ensuring that patients have orders to monitor wound(s) every shift and to notify the attending physician, Wound Nurse, and DON if any changes are noted. -Monitoring will be as follows. New admissions will receive a skin evaluation upon admission and this evaluation will be reviewed by the DON, ADON, or wound nurse. The wound nurse will evaluate and follow all pressure and complex non-pressure wounds including dehisced surgical wounds, hematomas, arterial and venous wounds, cellulitis, puncture wounds, diabetic wounds, and wounds with signs of infection. -A skin evaluation will be completed/reviewed for five (5) additional random patients weekly for four weeks, and then bi-weekly for two months for at least 3 (three) months of monitoring or until substantial compliance is obtained with wound evaluation, interventions, and notifications. The results of audits will be reviewed in the QA (quality assurance) monthly meeting to ensure the plan has been implemented, sustained and evaluated for its effectiveness. D. Removal of immediate jeopardy Based on the facility's plan above, the immediate jeopardy was removed on 7/31/24 at 10:30 p.m. However, deficient practice remained at a G level, actual harm, isolated. II. Explanation of Resident #1's hand and forearm injury and facility wound care expectations A. Professional reference - IV infiltrations and extravasations According to ivWatch, 2023, IV Infiltrations and Extravasations: Causes, Signs, Side Effects, and Treatment, retrieved 8/9/24 online from https://www.ivwatch.com/2020/05/27/iv-infiltrations-and-extravasations-causes-signs-side-effects-and-treatment/ Peripheral IVs are a common way of delivering IV fluids and medication. These IVs are typically inserted into the hand or forearm. IV infiltrations and extravasations occur when fluid leaks out of the vein into surrounding soft tissue. Common signs include inflammation, tightness of the skin, and pain around the IV site. Infiltration is the accidental leakage of non-vesicant solutions out of the vein into the surrounding tissue. This can occur with many antibiotics, dextrose solutions, or even normal saline. When left unchecked and untreated, IV infiltration can result in pain, swelling, compartment syndrome, and even amputation of the affected limb. When the leaked solution from an infiltration is a vesicant drug-one that causes tissue injury, blisters or severe tissue damage-it is referred to as an extravasation. Injuries from this type of IV failure can be severe and can lead to the loss of function in an extremity, and if the damage is severe enough, tissue death, known as necrosis. Left untreated and unchecked, IV infiltration can lead to excessive fluid in one or more compartments of the arm, causing damage to nerves, arteries, and muscles. This typically requires surgery to prevent a permanent loss of function and possible amputation. (continued on next page)

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

B. Facility policy and procedure

The Skin Evaluation and Interventions policy, issued on 9/4/18 and revised on 7/31/24 (during the survey), was provided by the NHA on 8/1/24 at 9:30 a.m. It read in pertinent part:

The facility will provide the necessary requirements to ensure that a patient receives the treatment and care in accordance with professional standards of practice related to skin integrity.

Procedure:

-Upon admission, the nursing staff will complete a full skin evaluation and examine for any

ulcerations or alterations in skin.

-Skin integrity concerns, both pressure and non-pressure wounds will be documented. Skin evaluations

will be reviewed to ensure appropriate interventions and care plans are in place.

-In addition, the nurse shall describe and document the following: 1.) Full evaluation of skin to include pressure and non-pressure skin integrity concerns with a description of the wound (if any). 2.)Subsequent skin evaluations will be scheduled weekly. 3) Nurse to follow treatment orders as prescribed and monitor skin integrity concerns. If a decline or worsening in wound status or skin integrity concern is identified, the concern will be documented and the physician, wound nurse, and DON will be notified. Treatment orders/interventions will be put in place accordingly.

C. Facility expectations - wound care

The wound care nurse (WCN) was interviewed on 7/31/24 at 10:48 a.m. The WCN said she conducted wound rounds to assess residents with pressure injuries and complex wounds. When a resident was admitted with a complex wound or developed a wound, the WCN conducted an initial assessment and communicated her findings with the resident's primary care physician (PCP). The facility did not have a wound care physician on staff. The WCN relied on the resident's physician to prescribe appropriate wound treatment orders based on her assessment of the wound.

The WCN said her wound assessments included a review of the resident's admission referral paperwork, a visual assessment of the wound, and measurements of the wound.

The WCN said if a resident's wound worsened, the floor nurses would notify her of the worsening wound and she would schedule the resident for wound rounds which occurred every Monday. She said the care of a wound was assigned to the floor nurse. The floor nurse was responsible for notifying her immediately of changes in the condition of a wound.

III. Resident #1

A. Resident status prior to and at the time of admission

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

Resident #1, age 69, was admitted to the facility from the hospital on 6/13/24. According to the July 2024 computerized physician orders (CPO), the resident's diagnoses included antineutrophilic cytoplasmic antibody vasculitis (autoimmune conditions leading to inflammation of blood vessels), kidney failure, pressure-induced deep tissue damage of the sacral region (buttocks), neuralgia, heart disease, and as of 6/13/24, renal dialysis.

Hospital records were printed on 6/12/24 and supplied to the facility for preadmission review. The resident's hospital treatment records documented:

The resident was admitted to the hospital on 5/29/24. While in the hospital the resident was diagnosed with hyperkalemia (excessive potassium in the blood) due to acute renal failure (inability of the kidneys to filter the body's blood) and was scheduled to start on dialysis to remove excess potassium and other waste products. Due to significant metabolic acidosis (a build of acid in the blood), the resident was started on a sodium bicarbonate infusion via a peripheral intravenous (IV) line (IV inserted directly into a vein).

On 5/30/24, the resident's IV site infiltrated (when the IV solution infuses into the tissue under the skin instead of the vein). The IV infiltration of sodium bicarbonate caused an edematous, purple (deep maroon) discoloration on the dorsal (back) hand and proximal (inside from the thumb) forearm of the right arm. The resident was referred for a hand surgical consultation. The surgeon felt that the wound was still evolving and had no surgical recommendations and instead ordered that the wound undergo strict continuous evaluation and monitoring for tissue progression until the wound declared itself in case surgical debridement (removal of dead tissue) by a wound care specialist was needed before any surgical intervention could be completed. The surgeon also ordered an occupational therapy evaluation and finger ROM (range of motion) to prevent stiffness while waiting to see the severity of the wound.

A wound assessment dated [DATE] (before facility admission) revealed the resident's right hand wound had progressed. The edges (were) irregular, and tissue within the area was raised deep purple, and mixed boggy and firm. The area of discoloration was raised above skin level. There was a fluid filled blister on the proximal aspect about 5.0 centimeters (cm) in length that stood about 1.0 cm tall, it was not draining. Distal to that was another area of fluid filled tissue and loose epithelium (skin) with occasional scant (small) areas of drainage occasionally. The resident was very protective of the arm and said it was quite painful. A radial (at the wrist) pulse was intact. The affected tissue (felt) firm on palpation, with the superficial epithelium overlying the deeper structure of loose skin with small areas (less than 0.4cm) split open. Scant serosanguinous (clear and bloody fluid appearing pink in color) drainage was noted on the dressing upon its removal. The resident's right hand and fingers continued to appear with pitting (fluid-filled) edema.

Orders read to continue with recommendations to monitor the wound for worsening. Manage right forearm drainage at the site of the blister and ensure comfort. Minimal wound care interventions are useful as there are no open wounds other than superficially from the fragile overlying epithelium. Apply emulsion dressing on the unit to any open or draining areas, followed by borderless foam. Secure with kerlix roll gauze or IV stretch net tubing and change at least daily and PRN (as needed) if soiled or no longer intact.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A facility admission assessment for pain, dated 6/13/24, revealed the resident had an achy, throbbing, and sharp pain in her legs, hands, and buttocks. The resident rated the pain at a level of 7 out of 10 (with 10 being the worst pain) and said it came and went. The pain affected sleep, mood, socialization, ability to perform activities of daily living, and physical mobility. The pain was resolved with pain medication. The resident was prescribed as needed oxycodone, tramadol, Tylenol, and scheduled gabapentin. B. Resident status after admission - worsening condition of the right forearm and hand wound- hospital transfer 7/11/24 and hospitalization [DATE] to 8/1/24. A physician's assistant (PA) exam note dated 7/5/24 revealed that the PA examined the resident at the request of the staff. The note documented Unspecified open wound of right hand due to bicarbonate infiltrate of the right upper extremity. The patient had this wound for several weeks at this point and is now worsening - Orthopedic surgery was consulted in the hospital (prior to facility admission), no surgical recommendations (at that time). Today staff is reporting increasing redness to the wound with purulent drainage, and yellow slough. Drainage leaking through bandage today. Skin: right hand wrapped in gauze - visible purulent drainage leaking through the bandage. Plan: Unspecified open wound of right hand: Referral already made to wound care clinic, unable to get patient in until mid-July. Continue to closely monitor. -There was no documentation to describe the wound bed, measurements and appearance of the wound. A nursing note, written by registered nurse (RN) #1, dated 7/6/24 read Wound care done to right arm. The resident was noted to have a black leathery covering over the entire wound on top of the arm. Measurements were as follows: The length of the entire area measures 22.8 cm, and the open area to the right outer part of the wound measured 10 cm wide and 5.8 cm long. The area had a yellow slough. The left side of the wound to the right hand was open measuring 0.5 cm. A nursing note dated 7/11/24 read in part, Received a call from EMS (emergency medical services) at 9:13 a. m., letting us know of a call to them from the resident's daughter. This writer informed them that the resident was ok but they will send EMS to check on her. This writer called the physician's office to obtain an order to send the resident to the emergency room . Went to the resident's room to let her know her daughter called EMS to have her sent to the hospital. The resident was on the phone speaking to someone about the transfer and agreed to go to the hospital . This writer changed the resident's dressing to the right arm per orders. EMS arrived and the resident was transferred to the hospital. The hospital emergency department (ED) treatment note dated 7/11/24 documented the reason for Resident #1's visit was arm pain. -Exam revealed Resident #1 had a large eschar (dry, black, hard necrotic tissue that interferes with healing) that was 20 cm or so long and 6.0 cm wide going from the back of her right hand into the forearm. The distal (lower end) edges of the wound with discharge and evidence of mild erythema (redness). The fingertips distally have substantial swelling. Range of motion reduced without substantial pain. -Diagnosis: open wound to the right hand with possible complications to the fingers and pressure injury of the skin of the buttock, unspecified injury stage. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Diagnostic tests: an x-ray of the forearm revealed infection concerns for osteomyelitis. Lab diagnostics wound cultures revealed the presence of pseudomonas, corynebacterium and MRSA (methicillin-resistant Staphylococcus aureus) in the wound on Resident #1's right arm ulceration. The treatment plan included: -The patient was started on Augmentin after consultation with ED (emergency department) pharmacist for appropriate antibiotics; -The plastic surgeon was consulted and stated that the patient's right arm wound would need to be debrided and wound care evaluated before she was able to perform any current grafting or further evaluation of the wound and exposed tendons; -Referral to an orthopedic surgeon as soon as possible for an assessment of the hand wound and surgical debridement; -Referral to physical medicine and rehabilitation specialist as soon as possible; -Referral to a plastic and reconstructive surgeon for consultation; and, -Follow up with emergency medicine. A PA exam note dated 7/12/24 documented, in part, that Resident #1 had an open wound on the sacrum as well as the right forearm, which is causing her pain. Her representative was concerned about these wounds and called EMS yesterday 7/11/24. Returned later in the evening. Regarding the resident's right hand and arm wound, the PA wrote: -The patient went out to the hospital and returned with a new order for amoxicillin for the wound on hand but otherwise to wait until the wound care clinic appointment on Tuesday 7/16/24. -Unspecified open wound of right hand sequela - due to bicarbonate infiltrate of the right upper extremity. Patient has had this wound for several weeks at this point and is now worsening and orthopedic surgery was consulted in the hospital, no surgical recommendations at this time. A nursing note dated 7/13/24 documented that Resident #1 had a change of condition due to being hypotensive, feverish, short of breath, and needing oxygen therapy. An IV access specialist tried to start an IV to infuse normal saline but was unable to access a vein for hydration therapy. The resident was sent to the hospital for evaluation and treatment and was admitted . A hospital treatment note dated 7/13/24 documented, Patient presented for emergency evaluation. Given her presenting symptoms, the severity of her illness, and illness/injury that poses a threat to life or bodily function. IV treatment was ordered to treat significant hypotensive drops in blood pressure along with monitoring. The patient will need to be debrided with wound care before she is able to perform any current grafting or further evaluation. The patient will require admission to the stepdown unit for close monitoring and treatment of her infection and borderline blood pressure. The patient's oral antibiotics were switched to IV antibiotic treatment with vancomycin and Zosyn. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A hospital treatment note dated 7/15/24 revealed the resident was admitted to the hospital on 7/13/24 for an infected arm wound. The patient had a right forearm bicarbonate extravasation in May 2024. This condition went through changes over the last couple of months and in the days leading up to this current admission, the patient's arm became more painful. The patient was started on Augmentin orally but was admitted after this was not helping. Additionally, she is known to have a decubitus ulcer, which has also been worsening recently. The note documented the resident was admitted due to sepsis (a serious infection in which the body responds improperly) secondary to an infected right forearm wound with tissue necrosis. The I&D (incision and drainage) procedure removed the top layer of necrotic skin, subcutaneous tissue (the deepest layer of skin), and (forearm) tendon. After the I&D procedure wound VAC (vacuum) placement was completed on 7/13/24. The resident's sacral pressure ulcer, without osteomyelitis. The wound was worsening and a wound vacuum (a device that gently removes fluid, reduces spelling and helps to clean the wound while promoting healing) in place. The resident remained in the hospital as of 8/1/24. C. Record review revealed the facility failed to assess, monitor, and report changes in the condition of the resident's right hand and forearm or seek medical treatment when the wound worsened. 1. A nursing note dated 6/13/24 documented Resident #1 was receiving antibiotics; her right hand had an infiltrated site with dark purple bruising and dressing. -This was the last skin assessment documenting the condition of the wound to the resident's right forearm and hand and it failed to include a description of the size of the wound and the status of the condition of the skin and blisters and drainage noted in the 6/11/24 assessment (see above). -Although another nursing note on 6/13/24 read that the dressing on the resident's arm had been changed and the resident tolerated it well, there was no further description of the wound. 2. A physician assistant (PA) note dated 6/14/24 documented that in addition to an open pressure-induced deep tissue damage of the sacral region causing the resident excruciating pain, the resident had an unspecified open wound on the right hand due to a bicarbonate infiltrate. -There was no evidence that the PA examined or assessed the condition of Resident #1's pressure or right hand and forearm wounds and there were no documented pain management recommendations. 3. The wound care nurse's (WCN) wound assessment dated [DATE] documented, Resident seen for skin evaluation this shift for possible skin integrity concerns. Recent labs and the health history and physical have been reviewed. The resident was noted with multiple clinical risk factors contributing to delayed healing. The WCN documented (in part) Resident #1's pressure injuries; a stage 3 pressure injury to the right lower and left lower buttocks as well as to the upper buttocks and a stage 4 pressure injury to the sacrococcygeal area. The resident's physician (PCP) was notified and orders were received. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-However, the WCN did not document an assessment of the wound to the resident's right hand and forearm. Further, although the PCP provided new wound orders based on the WCN's assessment; the PCP did not visualize the wounds in person. 4. Wound care orders for the resident's right hand and forearm were initiated 6/16/24 and read: Wound care: Right hand and forearm. Cleanse the site with wound cleanser or saline, pat dry, and apply a single layer of Xeroform cut to fit to the wound bed, apply non-adherent gauze and figure eight wrap with kerlix every other day and as needed. -The orders for the resident's treatment to the right hand and forearm wound were not changed and not reassessed for appropriateness and effectiveness based on the documentation of the wound's condition worsening and the development of necrotic and infected tissue (see above). 5. On 6/18/24, an order was placed by a nurse practitioner to refer Resident #1 to the wound clinic at the hospital for treatment recommendations to the sacral wound and the open wound to the right posterior (back) hand. Likewise, the June 2024 CPO documented an order for a referral to wound clinic for evaluation and treatment of sacral/coccygeal pressure ulcer (order date 6/21/24). -However, the resident never saw a wound care specialist while in the facility until the resident's representative called EMS to take the resident to the hospital for a wound assessment and treatment recommendation on 7/11/24. 6. On 7/6/24, RN #1 documented the black leathery covering over the entire wound on top of the arm. (see above). -There were no notes prior to this note to document the status and condition of the resident's wound showing the worsening of the wound and the development of the black necrotic tissue. -There was no documentation that the resident's PCP or the facility DON was notified of the condition and worsening of the resident's wound to her right hand and forearm. 7. A physician exam note dated 7/9/24 documented: Resident #1 has an open wound on the sacrum as well as the right forearm which is causing her pain. Right hand wrapped in gauze - visible drainage leaking through the bandage. -There was no evidence the physician examined or assessed the condition of Resident #1's wounds at that visit or that he was aware that the resident's wound had turned necrotic and was covered from the top of the right hand to the mid-forearm with black necrotic tissue. IV. Interviews A. Resident interview (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Rock Creek, LLC	4880 Ziegler Rd Fort Collins, CO 80528

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #1, alert and oriented per her 6/19/24 minimum data set assessment, was interviewed on 8/1/24 at 11:56 a.m. Resident #1 said she was still in the hospital being treated for her right hand and arm wound. Resident #1 said while she was in the facility she did not believe her wounds were addressed properly. and sometimes the nurses neglected to change the wound dressings on her buttocks per the wound care orders. Resident #1 said there were three nurses who seemed to know what they were doing; she said they did a good job with wound care and followed all the orders. However, other nurses did not seem to care and did not complete the wound care as ordered. Resident #1 said some days she started the day with the expectation that she would have a good day and then it turned out the day did not go as well as she hoped when her wound care was not performed. Nurses gave the excuse that they were running behind schedule and did not have time to change her wound dressings. Resident #1 said her wounds were painful. Pain medication managed the pain making it tolerable but a level of pain still existed. Resident #1 said the wound in her hand was constantly painful and rated the pain at a level of 7 out of 10. Resident #1 said when her hand and arm wound worsened, her daughter called 911. She did not want to go to the hospital but when emergency medical services (EMS) arrived, she agreed to go to the hospital for an assessment and she was glad she did because they found out she was on the wrong antibiotics for her infected wound. She said when she arrived at the hospital there was pus coming out of her wound at the knuckles and the tendon in her hand was exposed. She said she was very worried. She said she returned to the facility after seeing the emergency department doctors but her blood pressure started to drop and she said she developed a fever. The facility could not start an IV to give her fluids so she went back to the emergency department for treatment. The hospital performed tests, admitted her, and took her immediately to the operating room due to her infected skin. The resident said there was a lot of pus in the wound at the knuckles of her right hand that needed to be removed. She said the surgeon cleaned up the wound, removed the blackened skin, and removed the exposed tendon because it was not functioning. The hospital started her on IV antibiotics to cure the infection as it was spreading. Resident #1 said since that initial wound treatment she had received one skin graft and would need additional skin grafts. Resident [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024

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Center at Rock Creek, LLC	4880 Ziegler Rd Fort Collins, CO 80528

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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 0867

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.

41032

Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care.

Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of life and quality of care.

Findings include:

I. Facility policy and procedure

The Quality Assurance and Performance Improvement (QAPI) Program policy, reviewed in March 2024, was provided by the nursing home administrator (NHA) on 8/1/24 at 9:50 a.m. The policy read in pertinent part, The purpose of the QAPI program is to proactively and continually improve the way we serve and engage our residents and families, staff and other partners. To do this, employees will participate in ongoing QAPI efforts, which support our values. This work will be done under the guidance of the community QAPI committee and through the participation of applicable staff.

II. Review of the facility's regulatory record revealed it failed to operate a QA program in a manner to prevent repeat deficiencies and initiate a plan to correct deficient practice.

F684

During an abbreviated survey on 10/25/22 F684 Quality of Care was cited at a D level, no actual harm with potential for more than minimal harm that is not in immediate jeopardy, isolated.

During the abbreviated survey on 8/1/24 F684 Quality of Care was cited at a J level, immediate jeopardy to resident health or safety, isolated.

III. Cross-reference citations

Cross-reference F684: The facility failed to effectively assess, treat and report a worsening wound timely.

IV. Interview

The NHA was interviewed on 8/1//24 at 11:30 a.m. The NHA said the QAPI committee met monthly to discuss identified concerns and development improvement activities. The NHA said the committee discussed resident wounds for consideration for improvement plans but had not specifically identified the concerns regarding Resident #1's wounds.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065423	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said that she and the director of nursing (DON) would provide oversight and monitoring of the corrective actions and QAPI actions until the committee's findings were considered resolved through the QAPI process.