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	09/23/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure services met professional standards of practice for one (#9) of eight residents out of 13 sample residents.Specifically, the facility failed to:-Ensure nurses did not leave medications on Resident #9's bedside table; -Ensure Resident #9 when he was administered his medications to make sure he swallowed them; and; -Ensure nurses did not document in Resident #9's medication administration record (MAR) that the resident's medications were administered/swallowed when they were not.Findings include:I. Facility policy and procedureThe Medication Administration policy, revised December 2024, was provided by the regional nurse consultant (RNC) on 9/22/25 at 2:47 p.m. The policy revealed medications should be administered as prescribed by the attending physician. Medications may not be set up in advance and must be administered within one hour before or after their prescribed time. The staff administering the medication must record such information on the resident's MAR before administering the next resident's medication. Should a drug be withheld, refused, or given other than at the scheduled time it should be appropriately documented on the resident's medication administration record (MAR).The Six Rights of Medication Administration revealed a medication must be administered at the correct, scheduled time. Incorrect timing could affect the drug's therapeutic effectiveness and might lead to drug interactions. The nurse must accurately and completely document the medication administration in the resident's record. This included the drug given, the dose, the time, the route, and any resident reactions. Incomplete or incorrect documentation could lead to clinical errors.II. Resident #9A. Resident statusResident #9, age greater than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included encephalopathy (a medical condition characterized by a general dysfunction of the brain that affects cognitive function, consciousness, and behavior), non-traumatic intracranial hemorrhage (bleeding within the skull, or the brain cavity, which can damage brain tissue), cerebrovascular disease, vascular dementia, spastic hemiplegia (a type of cerebral palsy that affects one side of the body, typically the arm and leg) affecting right dominate side, muscle weakness and low back pain.The 9/2/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The resident required staff supervision or touching assistance for showering, upper body dressing and lower body dressing.B. ObservationsResident #9's room, which was a double occupancy room, was observed on 9/22/25 at 12:33 p.m. A souffle medication cup containing three white tablets and one brownish capsule was observed sitting on the resident's bedside table. At 12:34 p.m. the director of nursing (DON) observed the souffle medication cup containing the four medications. The DON removed the souffle cup from the room and took them to her office to be identified.C. Record reviewA care plan for being at risk for impairment due to cognitive function/dementia or impaired thought processes related to vascular dementia was revised on 6/25/24. The interventions were for staff to give step-by-step instructions one at a time as needed to support the resident's cognitive function. Staff were to keep the resident's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion. Staff were to identify themselves with each interaction. Staff were to face the resident when speaking and make eye contact. Staff were to reduce any distractions such as turning off the television, radio and/or close the door. Staff were to use simple direct sentences. Staff were to provide necessary cues. Staff were to stop and return if the resident became agitated.A care plan for alteration of neurological status related to hereditary ataxia (a condition that affects coordination and balance, causing uncoordinated jerky movements) and cerebral vascular disease was revised on 3/16/25. The interventions included for staff to cue and reorientate the resident as needed. Staff were to administer medications as the physician ordered. Staff were to monitor/document for any side effects and the effectiveness of the medications. Staff were to monitor/document/report to the resident's physician as needed any signs or symptoms of tremors, rigidity, dizziness, slurred speech and any changes in the resident's level of consciousness.A physician's order, dated 8/4/25 at 3:43 p.m., revealed to administer Baclofen (muscle relaxant and antispasmodic medication used to treat muscle spasms, stiffness and pain resulting from multiple sclerosis and other spinal cord conditions) 60 milligrams (mg) orally at midnight for spasticity.A physician's order, dated 9/15/25 at 9:35 a.m., revealed to administer two 250 mg capsules of Valerian Root (utilized for overall effect with the depression of central nervous system activity, including drowsiness, muscle relaxation, sedation and a decrease in anxiety) to equate to a total of 500 mg orally two

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain medical records in accordance with accepted professional standards and practices for one (#5) of eight residents reviewed for medical record accuracy out of 13 sample residents. Specifically, the facility failed to ensure accurate documentation of Resident #5's medication administration for Cardura (medication used to treat high blood pressure).Findings include:I. Facility policy and procedureThe Medication Administration Documentation policy and procedure, revised August 2025, was received from the regional nurse consultant (RNC) on 9/23/25 at 1:17 p.m. It read in pertinent part, It is the policy of this facility that medication administration should be documented as per physician order and to reflect if the resident accepted medication administration All current drugs and dosage schedules must be reported on the resident's medication administration record (MAR). Should a drug be withheld, it should be appropriately documented on the MAR.II. Resident #5A. Resident statusResident #5, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included chronic congestive heart failure and primary hypertension.The 9/18/25 minimum data set (MDS) assessment revealed Resident #5 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #5 required partial to substantial assistance from staff for most activities of daily living (ADL).B. Record reviewHospital records, dated 7/19/25, revealed Resident #5 was admitted to the hospital on [DATE] and discharged back to the facility on 7/19/25. Resident #5 was discharged from the hospital with an order for Cardura 8 milligram (mg) oral tablets, give 8 mg by mouth at bedtime.Review of Resident #5's September 2025 CPO revealed the following physician's order:Cardura 8 mg oral tablets, give 8 mg by mouth at bedtime related to primary hypertension, ordered 7/19/25 at 1:43 p.m. and discontinued 9/23/25 at 10:09 a.m. (during the survey).A physician's note, dated 7/21/25, revealed Resident #5 was receiving three medications in order to treat his enlarged prostate. The physician noted Resident #5 was also taking Cardura, and the physician was unclear why the resident was taking two alpha blocking medications (a class of medications that block the effects of a hormone on alpha receptors). -However, the physician did not document any hold (an official order from a healthcare provider to temporarily stop or suspend the administration of a prescribed medication for a resident) on Resident #5's Cardura or place a hold order for the medication.Review of Resident #5's MARs, from 7/19/25 through 9/23/25, revealed the following:The July 2025 (from 7/19/25 to 7/31/25) MAR documented Resident #5 received Cardura on 7/22/25, 7/26/25 and 7/29/25. The 10 other administration opportunities from 7/19/25 through 7/31/25 were documented as other/see nurse's notes.-However, Resident #5 was not administered any doses of Cardura during that time (see interviews below).The August 2025 (from 8/1/25 to 8/30/25) MAR documented Resident #5 received Cardura on 8/1/25, 8/5/25, 8/12/25, 8/15/25, 8/19/25, 8/26/25, 8/28/25 and 8/30/25. Resident #5 was out of the facility from 8/7/25 through 8/10/25. The 19 other administration opportunities from 8/2/25 through 8/31/25 were documented as other/see nurse's notes.-However, Resident #5 was not administered any doses of Cardura during that time (see interviews below).The September 2025 (from 9/1/25 to 9/22/25) MAR documented Resident #5 received Cardura on 9/9/25 and 9/16/25. The 20 other administration opportunities from 9/1/25 through 9/22/25 were documented as other/see nurse's notes. -However, Resident #5 was not administered any doses of Cardura during that time (see interviews below). Review of the progress notes revealed the nursing staff documented Resident #5's Cardura was unavailable and the physician was aware almost daily from 7/19/25 through 9/22/25.Review of Resident #5's electronic medical record (EMR) did not reveal any documentation regarding the resident's Cardura being withheld or the reason why it was withheld. III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 9/23/25 at 12:40 p.m. LPN #1 said she administered medications by giving the medication cup to the resident and watching the resident take all of their medications before marking the medications as administered in the resident's MAR. LPN #1 said she administered medications this way because she did not want to have to go back into the resident's MAR and edit it if the resident refused a medication or was unavailable to take their medications. LPN #1 said if a medication was on hold by the physician, it was usually crossed out on the MAR. LPN #1 said if the medication was on hold but was not crossed out on the MAR, she would contact the physician to see why it was not crossed off, mark the medication as held and document in the progress notes that the medication was held and what the reason for holding the medication was. LPN #2 was interviewed on 9/23/25 at 2:14 p.m. LPN #2 said she waited to mark a medication as administered on the MAR until after