STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065291	A. Building 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 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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-2(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 (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 - Minimal harm or potential for actual harm Residents Affected - Few	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 minute.On [DATE] at 9:30 a.m. the resident had a normal level of consciousness, rambling speech and equal hand grasps. Vital signs: blood pressure 191/90 mmHg, heart rate 89 bpm, respirations 15 per minute.On [DATE] at 9:45 a.m. the resident had a normal level of consciousness, rambling speech and equal hand grasps. Vital signs: blood pressure 187/94, heart rate 82 bpm, respirations 16 per minute.On [DATE] at 10:15 a.m. the resident had a normal level of consciousness, rambling speech and equal hand grasps. Vital signs: blood pressure 190/98, heart rate 80 bpm, respirations 15 per minute.On [DATE] at 10:45 a.m. the resident had a normal level of consciousness, rambling speech and equal hand grasps. Vital signs: blood pressure 184/86 mmHg, heart rate 78 bpm, respirations 15 per minute.On [DATE] at 11:15 a.m. the resident had a normal level of consciousness, rambling speech and equal hand grasps. Vital signs: blood pressure 187/91 mmHg, heart rate 82, respirations 16 per minute.On [DATE] at 11:45 a.m. the resident had a normal level of consciousness, rambling speech and equal hand grasps. Vital signs: blood pressure 194/96 mmHg, heart rate 77 bpm, respirations 15 per minute.On [DATE] at 12:45 p.m. the resident had a normal level of consciousness, normal speech and equal hand grasps. Vital signs: blood pressure 186/82, heart rate 73, respirations 15 per minute.On [DATE] at 1:45 p.m. the resident had a normal level of consciousness, normal speech and equal hand grasps. Vital signs: blood pressure 184/81 mmHg, heart rate 81 bpm, respirations 15 per minute.A CPO, dated [DATE] at 1:32 p.m., was initiated for hydralazine 25 mg by mouth every eight hours as needed for high blood pressure with a systolic reading of greater than 180. The medication was not administered.-However, Resident #1's blood pressure had remained high for over four hours after the fall before the facility notified the physician.A nurse progress note, dated [DATE] at 1:56 p.m., revealed Resident #1's blood pressure did not recover in four hours following her fall. Resident #1's blood pressure remained in the 180s range. The nurse contacted the physician regarding the fall and high blood pressure readings and the physician gave a new order for hydralazine 25 mg every eight hours as needed for a systolic blood pressure reading greater than 180. A nurse progress note, dated [DATE] at 3:00 pm., revealed Resident #1's representative and power of attorney (POA) were informed regarding Resident #1's fall and insisted Resident #1 be (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transferred to the hospital emergency department for evaluation. The registered nurse (RN) documentation revealed the RN did due diligence and educated the family members there were no signs of serious injury or neurological damage after the fall. The POA was informed Resident #1 had high blood pressure and had a new order for medication to control the high blood pressure. The manager on duty returned to the facility to transport Resident #1 to the emergency department. Resident #1 was changed and prepped for transfer to the emergency department. The RN documented the blood pressure had normalized by the afternoon without using the hydralazine. The hospital progress notes, dated [DATE], revealed Resident #1's representative was notified at 3:00 p.m. that Resident #1 had fallen in the morning. The representative went to visit the resident at the facility and found Resident #1 was not at her baseline. The representative said Resident #1 was holding her left arm and was uncomfortable. Resident #1 arrived at the hospital by facility transport van. Resident #1's blood pressure at 5:50 p.m. at the emergency department was 208/115.IV. Staff interviewsRN #1 was interviewed on [DATE] at 2:52 p.m. RN #1 said after a resident had a fall, it was the facility's policy to have the resident assessed by a registered nurse. RN #1 said the assessment included a measurement of vital signs, including blood pressure. RN #1 said the post-fall assessments were documented in the resident's electronic medical record (EMR) and also on the facility's neurological assessment form, if the fall was unwitnessed, or if the resident struck their head while falling. RN #1 said when a resident had high blood pressure, it was the nursing standard to recheck the blood pressure to verify the result. RN #1 said if the reading were high, it would indicate the resident had a heart issue or maybe elevated pain. RN #1 said if a resident had continuous high blood pressure after about three minutes, she would contact the physician and report the resident's condition. RN #1 said it was not a good idea to monitor high blood pressure for hours without a physician's awareness and orders. RN #1 said the facility had medication to lower blood pressure in the facility's emergency medication supply, and a nurse could access the medication without delay after a physician's order was initiated.The DON and the nursing home administrator in training were interviewed together on [DATE] at 3:15 p.m. The DON said after Resident #1 fell, nursing staff followed policy and completed neurological assessments and notified the physician. The DON said post-fall assessments included a complete body assessment and measuring vital signs. The DON said the purpose of frequent assessments was to closely monitor residents so that nursing staff could identify concerning changes in assessment and implement interventions and notify the physician if necessary. The DON said the neurological assessments were completed after an unwitnessed fall or anytime a resident hit their head. The DON said the neurological assessments included looking at skin for trauma or new deformities, pain, acting abnormally and changes in vital signs. The DON said Resident #1 had a history of high blood pressure and had fluctuations in blood pressure before the [DATE] fall, but had not previously required new medications to lower blood pressure. The DON said the neurological assessments completed on [DATE] did not reveal a change in Resident #1's normal status, and Resident #1 was monitored appropriately. The DON said Resident #1 had no signs of serious injury, moved all major joints, and did not grimace or hold her head. The DON said that when the family requested Resident #1 to be evaluated at the hospital, the facility's manager on duty transported Resident #1 in the facility van because the nurse assessment documented Resident #1 was stable and had no indicators for ambulance transport.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 emergency department for an evaluation.The facility interviewed all staff on duty who were involved in care for the resident on the day of the fall.The staff member who witnessed the occurrence provided a written incident statement that revealed Resident #1 was assisted from the dining room to her room and was often assisted without foot pedals and Resident #1 had previously been able to lift her feet when requested while she pushed her in the wheelchair. The statement revealed Resident #1 sat in her chair as usual, but the resident leaned forward and landed on the floor. Inspection of Resident #1's wheelchair revealed the foot pedals were not attached to her wheelchair and therefore Resident #1 was unable to keep her feet off the floor while being transported by a staff member. The investigation documented the nurse on duty immediately attached foot pedals to Resident #1's wheelchair.The investigation revealed that a registered nurse (RN) completed a post-fall assessment, and Resident #1 was able to move all her extremities, had no facial grimacing, and had a laceration on her forehead with a bruise forming on the backs of her right and left hands. The assessment documented that Resident #1 had no changes in her cognitive status.The investigation revealed Resident #1 was transferred to a hospital for higher-level care for a C1 spine fracture. The family declined surgical care and placed Resident #1 on hospice care and Resident #1 passed away on [DATE].The facility investigation revealed that the facility followed policy, procedure, and manufacturer guidelines for wheelchair use, and the staff member involved had been adequately trained in using the equipment.V. 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 high blood pressure, diabetes mellitus and Alzheimer's disease.The [DATE] minimum data sets (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-tippers 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 when her 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 to the middle of the upper forehead at her hairline. Resident #1 was unable to follow commands, and the nurse completed passive (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	range of motion for all major joints while Resident #1 was on the floor. Vital signs were normal except for the 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 progress note did not include the time of notification or response from those notified. The record review revealed there were no new CPOs given at the time of the initial fall notification. -Review of Resident #1's vital signs following the fall revealed the resident's blood pressure readings remained high for over four hours after the fall before the facility notified the physician for a physician's order to address the high blood pressure.Cross reference F684 for failing to notify the physician of high blood pressure readings.A nurse progress note, dated [DATE] at 3:00 pm., revealed Resident #1's representative and power of attorney (POA) were informed regarding Resident #1's fall and insisted Resident #1 be transferred to the hospital emergency department for evaluation. The RN documentation revealed the RN did due diligence and educated the family member there were no signs of serious injury or neurological damage after the fall. The POA was also informed Resident #1 had high blood pressure and had a new order for medication to control high blood pressure. The manager on duty returned to the facility to transport Resident #1 to the emergency department. Resident #1 was changed and prepped for transfer to the emergency department. -A review of Resident #1's electronic medical record (EMR) did not reveal a time or assessment status of Resident #1 left for the emergency department.The hospital progress notes, dated [DATE], revealed Resident #1's representative was notified at 3:00 p.m. that Resident #1 had fallen in the morning. The representative went to visit the resident at the facility and found Resident #1 was not at her baseline and said Resident #1 was holding her left arm and was uncomfortable. Resident #1 arrived at the hospital by facility transport van. Resident #1's blood pressure at 5:50 p.m. at the emergency department was 208/115.The hospital Xray report for left arm pain, dated [DATE], revealed Resident #1 had a mild superior subluxation (joint dislocation) of the elbow and an age undetermined of the radial neck (elbow). The hospital computerized tomography (CT) scan of the cervical spine, dated [DATE], revealed Resident #1 had a type 2 dens/odontoid fracture with displacement of the dens/odontoid and anterior ring by 5 millimeters (mm). Fracture lines were seen through the posterior ring of C1 in two places.Resident #1 was diagnosed on [DATE] at the emergency department with a C1 spine fracture, closed head injury, wedging of the thoracic spine, and left radial head/neck impacted fracture. A rigid cervical collar was placed on Resident #1, and a splint was placed on the left upper extremity. Resident #1's representative was informed of the diagnoses and the decision was made to transfer Resident #1 to a higher level of care for appropriate specialty management with neurosurgery capability. Resident #1 was transferred in fair condition on [DATE] via rotor flight transport.VI. Staff interviewsCertified nurse aide (CNA) #1 was interviewed on [DATE] at 2:30 p.m. CNA #1 said she frequently used wheelchairs and assisted residents with mobility inside the facility. CNA #1 said she received education and training on safe wheelchairs and equipment in her CNA training, and also a few weeks ago. CNA #1 said wheelchair foot pedals were used to lift the resident's feet off the floor and were adjustable to help position the leg and foot placement of each resident. CNA #1 said staff were educated not to remove foot pedals from wheelchairs until the residents were checked off and able to maneuver themselves independently. CNA #1 said that when foot pedals were missing from a wheelchair and were needed, staff would look around the facility, in closets or storage rooms, to locate the required appropriate wheelchair equipment. CNA #1 said she was unsure how to determine if the wheelchair equipment in use (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was as ordered or evaluated. She said she continued mobility equipment use based on what was in each resident's room, and if the equipment was not appropriate or adequate, she would talk to the floor nurse.RN #1 was interviewed on [DATE] at 2:52 p.m. RN #1 said that after a resident fell in the facility, the facility policy required the RN on duty to complete a post-fall assessment. The RN said the nurse should try not to move the resident until a head-to-toe assessment was completed and the nurse determined it was safe to move the resident. The RN said after the resident was assisted to their bed, the facility policy required close monitoring for three days. The RN said the monitoring intervals started frequently, every 15 minutes, and then went to every 30 minutes, then every four hours, then every eight hours, and then once per shift. The RN said that after the resident assessment was completed, the RN was responsible for notifying the physician and family, and documenting the fall occurrence, notifying the physician, and documenting if the physician gave new orders. The RN said the physician could be informed by voicemail or directly. The RN said a nurse did not always need a physician's order to call 911 and would base the decision to call 911 on nursing judgment and education. The RN said the decision to move a resident after a fall where the resident hit their head would depend on assessment and judgment. The RN said a high blood pressure reading after a fall could be evidence of pain, but the RN should call the physician if the resident's blood pressure was rising after a head injury.The director of rehabilitation (DOR) was interviewed on [DATE] at 3:06 p.m. The DOR said wheelchair assessments were completed by the occupational therapist (OT). The DOR said residents were assessed for mobility status when they were admitted to the facility. The DOR said if the OT determined the resident required a wheelchair for mobility, the facility provided a wheelchair for the resident's use. The DOR said the maintenance department was responsible for inspecting wheelchair equipment for safety and providing wheelchair maintenance. The DOR said Resident #1 did not have a wheelchair assessment that determined whether or not foot pedals were required for Resident #1. The DOR said nursing staff would know from the residents' EMR or care plan what equipment was needed for each resident and how the nursing staff would be aware of changes in equipment required, such as when a resident had a change in status and required different equipment. The DOR said if a wheelchair assessment was not available, nursing staff were able to screen residents and get a general idea of what equipment was required for resident care.The DON and the nursing home administrator in training were interviewed together on [DATE] at 3:15 p.m. The DON said after Resident #1 fell, nursing staff followed policy and completed neurological assessments and notified the physician. The DON said post-fall assessments included a complete body assessment and measuring vital signs. The DON said the purpose of frequent assessments was to closely monitor residents so that nursing staff could identify concerning changes in assessment and implement interventions and notify the physician if necessary. The DON said the neurological assessments were completed after an unwitnessed fall or anytime a resident had a head strike. The DON said the neurological assessments included looking at skin for trauma or new deformities, pain, acting abnormally, and changes in vital signs. The DON said the neurological assessments completed on [DATE] did not reveal a change in Resident #1's normal status, and Resident #1 was monitored appropriately. The DON said Resident #1 had no signs of serious injury, moved all major joints, and did not grimace or hold her head. The DON said that when the family requested Resident #1 to be evaluated at the hospital, the facility manager on duty transported Resident #1 in the facility van because the nurse assessment documented Resident #1 was stable and had no indicators for ambulance transport.The DON said the interdisciplinary team (IDT) reviewed the [DATE] fall and discussed that nursing staff would receive education on the use of foot pedals with wheelchairs. The DON said there had not been additional occurrences or injuries that involved (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	wheelchairs since [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065291	A. Building 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 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 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. **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.