STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065423	A. BUILDING _____ B. WING _____	04/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTER AT ROCK CREEK, THE	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** - 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 staff interview and record review the facility failed to ensure one resident (Resident #1) of three sample residents, received treatment and care in accordance with professional standards of practice. Specifically, the facility failed to ensure Resident #1's, physician's orders [REDACTED]. Cross Reference: F760 Significant Medication Error Findings included: Policy and procedure The PICC (peripherally inserted central catheter) Line Flushing Policy and Procedure, revised 9/23/19 documented The following information should be recorded in the resident's medical record: -The date and time the medication was administered. -Total amount of flush administered. -The route and rate of medication administration. -The condition of the IV site before and after administration. -Notification of physician, if there are any complications. -Resident's response. -The signature and title of the person recording the data. Resident status Resident #1, age 83, admitted on [DATE] and discharged from the facility on 4/16/2020. According to the face sheet [DIAGNOSES REDACTED]. The resident did not have a minimum data set as she was only in the facility for five days. Resident #1's baseline care plan documented she was alert and cognitively intact and required one person assistance for activities of daily living (ADL). The baseline care plan did not indicate the resident had an IV. Record review The 4/11/2020 hospital discharge plan of care documented the resident was to receive [MEDICATION NAME] 2g (grams) IV every eight hours, 5/20/2020 was the planned IV end date, do not stop without specific order (po (by mouth) tx (treatment) after IV planned). There were no orders indicating the resident had an IV. The April 2020 Medication Administration Record [REDACTED]. The order start date was 4/14/2020. Resident #1 received her first dose at 4:00 p.m. on 4/14/2020; missing seven doses since admission. There was nothing on the MAR indicated [REDACTED]. The hospital consult follow up notes dated 4/10/2020 documented the resident's assessment was a right knee prosthetic joint infection. She has Staphylococcus aureus infection of her right prosthetic knee joint. The plan was to change Vacomyacin to [MEDICATION NAME] and to anticipate 6 weeks IV antibiotic with oral antibiotic suppression afterwards. Transfer plans for tomorrow noted, antibiotics orders are in discharge instructions. Upon review of the facility progress notes the following information was found: -The 4/16/2020 social services noted read in pertinent part: Received call from resident's daughter. She has made arrangements for (resident name) to get her infusions through infusion clinica and set up HH (home health). She requested immediate discharge this morning. -There were no notes indicating staff had provided care to the PICC line site when administering the resident's IV ABX. -There were no notes indicating discussions with the physician upon his identification of missing the prescribed ABX (see interview below). -There were no notes indicating the facility had spoken with the family to provide notification of missing seven days of the residents IV antibiortic (ABX). Family interview The resident's emergency contact was interviewed on 5/5/2020 at 9:00 a.m. She said she believed the facility failed the resident and once she found out they missed administering the ABX she immediately wanted to have her discharged from the facility and arrange home health. Staff interviews The physician was interviewed via phone on 4/17/2020 at approximately 1:00 p.m. He said when he came to the facility on [DATE] he reviewed Resident #1's medical record and saw documentation regarding her infection. He said he reviewed her medication list and thought it was strange that she did not have an order for [REDACTED].#1 was interviewed on 4/17/2020 at 2:15 p.m. She said she was the nurse who admitted Resident #1 and she recalled asking her about IV site on her arm. She said the resident did not know why she had it. She said she passed it on to the oncoming nurse when her shift was over; however she did not do any further review of the resident's medical records to research why she had an IV in her arm. She said when she returned to work on 4/14/2020 she learned that the resident was to receive ABX upon admission. The DON was interviewed on 4/17/2020 at approximately 1:45 p.m. She said once the physician made her aware the resident was to start the IV ABX upon admission, she immediately wrote the order and notified nursing staff.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review the facility failed to ensure one resident (Resident #1) of three sample residents, was free of any significant medication errors. Specifically, the facility failed to ensure Resident #1 who was a new admission, received her intravenous (IV) antibiotic (ABX) which she received at the hospital and was ordered to continue upon admission to the facility. Cross Reference F684: Quality of Care Findings include: Resident status Resident #1, age 83, admitted on [DATE] and discharged home on[DATE]. According to the face sheet [DIAGNOSES REDACTED]. The resident did not have a minimum data set assessment completed as she was only in the facility for five days. Resident #1's baseline care plan documented she was alert and cognitively intact and required one person assistance for activities of daily living (ADL). The baseline care plan did not indicate the resident was receiving IV therapy. Record review The hospital consult follow up notes dated 4/10/2020 documented the resident's assessment was a right knee prosthetic joint infection. She has Staphylococcus aureus infection of her right prosthetic knee joint. The plan was to change [MEDICATION NAME] to [MEDICATION NAME] and to anticipate 6 weeks IV antibiotic with oral antibiotic suppression afterwards. Transfer plans for tomorrow noted, antibiotics orders are in discharge instructions. The 4/11/2020 hospital discharge plan of care documented the resident was to receive [MEDICATION NAME] 2g (grams) IV every eight hours, 5/20/2020 was the planned IV end date, do not stop without specific order (po (by mouth) tx (treatment) after IV planned). The April 2020 Medication Administration Record [REDACTED]. The order start date was 4/14/2020. -Resident #1 received her first dose at 4:00 p.m. on 4/14/2020; missing seven doses since admission date of [DATE]. Staff interviews The physician was interviewed via phone on 4/17/2020 at approximately 1:00 p.m. He said when he came to the facility on [DATE] he reviewed Resident #1's medical record and saw documentation regarding her infection. He said he reviewed her medication list and thought it was unusual that she did not have an order for [REDACTED]. Registered nurse #1 was interviewed on 4/17/2020 at 2:15 p.m. She said she was the nurse who admitted Resident #1 and she recalled asking her about the IV site on her arm. She said the resident did not know why she had it. She said she passed it onto the oncoming nurse when her shift was over; however, she did not do any further review of the resident's medical records to research why she had an IV in her arm. She said when she returned to work on 4/14/2020 she learned that the resident was to receive ABX upon admission. The DON was interviewed on 4/17/2020 at approximately 1:45 p.m. She said once the physician made her aware the resident was to start the IV ABX upon admission, she immediately wrote the order and notified nursing staff. She said she had started some training with nurses to ensure that at least two nurses reviewed all orders for newly admitted residents to avoid this type of error in the future.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation and interviews staff did not use proper hand hygiene prior to serving resident ' s room trays. Specifically staff were observed not washing or sanitizing their hands prior to delivering the resident's lunch meals which

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

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) were on room trays. Observations On 4/14/2020 at 12:00 p.m. on the east wing of the building staff were observed preparing and passing food trays for the residents lunches,. Trays were brought in a tall food cart to a common area by the dietary staff close to the nurse ' s station. Certified nurse aides (CNA) and dietary staff helped prepare each tray with napkins, utensils and drinks. Trays were grabbed one by one and delivered to the appropriate rooms. Staff did not use hand hygiene prior to carrying the lunch trays into the resident ' s rooms. Staff helped the residents with their food trays by removing lids, cutting food and handing napkins to the resident. After leaving the residents room ' s, staff were observed using the wall sanitizers four out of eight times. As staff returned to get more trays they were observed reaching in their pockets for pens, writing notes at the nurse ' s station and repeating the process to prepare each lunch tray. They did not sanitize their hands before taking new room trays or upon entering a resident ' s room. Staff Interviews CNA #1 and restorative aide (RA) was interviewed on 4/14/2020 at 1:00 p.m. Both stated they had been trained to wash their hands prior to delivering room trays as well as when they left the residents rooms. Both stated they were taught that hand washing helped prevent the spread of infection. The director of nursing (DON) was interviewed on 4/23/2020 at 12:30 p.m. She said that staff should always perform hand hygiene prior to serving resident ' s their meal trays and hand hygiene should be performed for residents prior to them receiving their food.