STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065174	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Health and Rehabilitation Center	1420 S 3rd Ave Sterling, CO 80751

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on interviews and record review, the facility failed to ensure proper treatment and services to maintain hearing for one (#3) of three residents reviewed for hearing problems out of eight sample residents. Specifically, the facility failed to ensure an audiology referral for Resident #3 was followed up on timely when recommended and ordered by the physician. Findings include: I. Resident #3 A. Resident status Resident #3, age 83, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included falls, dementia with mild agitation and anxiety disorder. The 4/11/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of five out of 15. She required physical assistance with all activities of daily living. B. Resident representative interview Resident #3's representative was interviewed on 4/23/24 at 9:00 a.m. She said she was the legal power of attorney for the resident. She said the resident's physician had ordered an audiology consult because the resident had been complaining of dizziness and headaches and all the other testing had not revealed any abnormalities. She said the physician had ordered the referral on 4/9/24 and the facility had yet to arrange the consult. Resident #3's representative said she felt like the facility was delaying potential treatment for Resident #3. C. Record review (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Sterling Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1420 S 3rd Ave Sterling, CO 80751	

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/1/24 nursing progress note documented the resident's representative called the nurse to Resident #3's room to show her a knot on the right side of the resident's head, directly above her ear. The resident said her head felt like it was splitting open. The nurse practitioner (NP) ordered for the resident to be sent to the emergency room for an evaluation and treatment for uncontrollable head pain. The 3/6/24 nursing progress note documented the resident had returned from the emergency room with a recommendation for a referral to an ENT (ear, nose and throat physician). It indicated the nurse would follow up on making an appointment for Resident #3. The 3/20/24 nursing progress note documented an order was received from the NP to see a specific ENT physician. It indicated the NP faxed the paperwork to the ENT physician's office. -However, according to the director of nursing (DON) the specific physician was not an ENT, but rather an audiologist (see DON interview below). The 4/16/24 nursing progress note documented the nurse reached out to the physician regarding the audiology referral. The physician said they sent the referral on 4/9/24. -This was 34 days after the original referral was recommended by the emergency room physician on 3/6/24. -The facility failed to follow up to ensure the resident saw the audiologist timely. The resident did not see the audiologist until 51 days after the initial recommendation. II. Staff interviews The nursing home administrator (NHA) and DON were interviewed on 4/23/24 at 10:50 a.m. The DON said she was responsible for follow-up on any referrals and recommendations to outside providers made by the physicians. She said she was not the DON at the time of the emergency department recommendation made on 3/6/24 for Resident #3. She said the former DON did not follow up on the recommendation timely. The DON said she reached out to Resident #3's primary care physician (PCP) on 4/1/24 (a month after the recommendation was made by the emergency room physician). She said the PCP wanted to have the resident see an audiologist prior to an ENT. She said she did not send the referral information to the audiologist until 4/23/24. The DON said the appointment was confirmed the day before (4/22/24) for Resident #3 to see the audiologist on 4/26/24 at 10:30 a.m. The DON confirmed the appointment was not made until 45 days after the initial recommendation.