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	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Rehabilitation and Nursing LLC	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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review and interviews, the facility failed to ensure residents were free from physical restraints for one (#3) of one resident out of 15 sample residents. Specifically, the facility failed to ensure Resident #3 was not restrained in his wheelchair using a Hoyer lift (mechanical lift) sling. Findings include: I. Facility policy and procedures The Abuse Policy, revised 6/11/24, was provided by the nursing home administrator (NHA) on 12/30/24 at 10:50 a.m. The policy revealed every resident had the right to be free from all forms of abuse: verbal, sexual, physical, mental, neglect, corporal punishment and involuntary seclusion. The facility did not condone resident abuse and should take every precaution to prevent resident abuse. All occurrences of resident abuse, suspected abuse, neglect and injuries of unknown source should be promptly reported to the facility abuse coordinator for investigation. Resident abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment of a resident resulting in physical harm or pain, mental anguish or deprivation of goods or services that were necessary to attain or maintain physical, mental or psychosocial well being. Abuse included any type of abuse that was facilitated, enabled through use of technology or social media. Physical abuse was abuse that resulted in bodily harm with intent. This included hitting, slapping, pinching, kicking and controlling behavior through corporal punishment and willful neglect of the resident's basic needs. Willful was defined as the individual might have acted deliberately, not that he/she must have intended to inflict injury or harm. Mistreatment was defined as an inappropriate treatment or exploitation of a resident. All new employees would complete training modules on Abuse & Neglect, The Elder Justice Act, Resident Rights Essentials, Behavioral Health Options for Older Adults and Handling Aggressive Behaviors upon hire during the orientation period. All employees would complete semi-annual training modules on Abuse & Neglect and the Elder Justice Act and annual training modules on Resident Rights Essentials, Behavioral Health Options for Older Adults, and Handling Aggressive Behaviors. General staff meetings were regularly held and might include in-services, training or reminders regarding facility policy on abuse, neglect, exploitation and/or misappropriation of resident property as indicated. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility would ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property were reported immediately, but no later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury. The report could be no later than 24-hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury. The report would go to the administrator of the facility, to other officials (including to the State Survey Agency and Adult Protective Services where state law provided jurisdiction in long term care facilities and the office of long term care ombudsman) in accordance with State law through established procedures. All employees of this facility must immediately report any suspected, observed or reported incidents of resident abuse, neglect, misappropriation of resident property, whether by staff members, family members or any other persons to the administrator or the administrator's designee. The administrator served as the abuse coordinator of the facility. This facility permitted the administrator or the administrator's designee to report suspected crimes or allegations of abuse to law enforcement, the State Survey Agency, Adult Protective Service in place of the staff member who witnessed the suspected crime or reported the allegation of abuse. The director of nursing or designee would ensure that the medical director and the resident's representative (as applicable) were notified of all incidents or suspected incidents of resident abuse, mistreatment, neglect or injury of unknown source. Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported; the administrator, or his/her designee, should conduct an investigation of the alleged incident. The administrator or designee should interview any staff members, residents, family members or any others who may have knowledge of the incident and document a summary of interviews completed. The administrator or designee should report the results of all investigations to the State Survey Agency within five working days of the incident and other agencies as required by state law or regulation. If the alleged violation were substantiated, appropriate corrective action would be taken. When an employee of the facility abused or was suspected of abuse of a resident, the employee would be placed on immediate suspension, directly escorted by a staff member out of the facility and not permitted to return until the investigation was completed. When the investigation showed that abuse did not occur, the employee was reinstated. When the investigation showed abuse did occur, the employee would be subject to disciplinary action up to and including termination. The facility would report to the appropriate licensing authority and/or other required agencies any confirmed occurrences of abuse or any knowledge it had of any actions by a court of law which would indicate an employee was unfit for service. II. Incident of physical restraint involving Resident #3 on 3/30/24 The NHA provided the facility's investigative documents related to the physical restraint of Resident #3 on 12/30/24 at 4:22 p.m. The documents revealed: The NHA received a phone call on 3/30/24 at 10:30 p.m. from certified nurse aide (CNA) #4. CNA #4 reported that during shift report, she was told by the evening shift CNAs that Resident #3 had been observed sitting in a wheelchair near the nurses station with a Hoyer lift sling brought up between his legs, brought up across his shoulders and hooked onto his wheelchair handles. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigative documents included a typed statement from CNA #6 that was dated 3/31/24 (not timed) and revealed CNA #6 observed (Hoyer) leg straps pulled through (between) Resident #3's legs, under his arms and hooked to his wheelchair handles. The resident was in this position when she arrived for her shift at 2:00 p.m. CNA #6 did not think about this position since the director of nursing (DON) was there. CNA #6 did not observe the resident in a different position or having the straps removed. The investigative documents included a typed statement from CNA #5 that was dated 3/31/24 (not timed) and revealed CNA #5 observed Resident #3 at the nurses station and the resident was having a bad night. She observed a (Hoyer) lift sling was brought up between his legs, over his shoulders and hooked on the wheelchair handles. CNA #5 did not observe who put the resident in this position, however she noticed the resident in this position when she was getting the resident ready for bed. The investigative documents included a typed statement from CNA #3 that was dated 3/31/24 (not timed, dated/signed) and revealed CNA #3 observed the resident kept sliding out of his wheelchair. The DON and registered nurse (RN) #3 were the only two staff members that were at the nurses station with the resident. CNA #3 did not observe who placed the resident in this position. CNA #3 first observed the resident at 4:00 p. m. with the bottom part of the (Hoyer) lift sling crossed over and placed on the handles of the wheelchair. RN #3's typed and signed statement, dated 3/31/24 at 8:04 a.m., revealed the DON was in charge of Resident #3 and was having trouble getting the resident to stay in bed. The resident had ripped out his ostomy, was really restless and trying to get out of bed. The resident said he had to go drive a tractor. The DON said it was safer to get him up so he did not end up on the floor. The statement documented RN #3 and the DON got the resident up in his wheelchair and placed him by the nurses station. Right away he was already trying to get up and walk. RN #3 and the DON had to get him up multiple times to scoot him back into his wheelchair. A member from therapy got foot pedals to see if this would help with positioning. The foot pedals did not help, because the resident kept putting his feet over them and sliding down. The DON said to hook the sling (Hoyer) straps to the wheelchair. The DON was hoping to catch his bottom before he slid down from the wheelchair. According to RN #3's statement, Resident #3 never left their sight, one of them always had eyes on the resident. The lift sling straps (Hoyer) at one time went between his legs, over his shoulder and then attached to the handles of the wheelchair. The resident was able to move his arms and it was not tight, even when he slid down in the wheelchair. The resident was always within arms distance of either the DON or RN #3. The statement documented it was not the DON or RN #3's intention to restrain Resident #3 in the wheelchair. It was more of a fail safe to keep the resident from sliding forward and falling. The alleged assailant summary of the interview, dated 3/31/24 at 7:00 a.m., with the DON revealed the resident was having a bad night. The DON said they had to have the resident up at the nurses station quite a bit. The DON said there was nothing about the sling (Hoyer) that was different, they were just hanging there. -However, the DON admitted to the police that she placed the sling (Hoyer) between Resident #3's legs and attached the straps to the wheelchair handles. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A witness interview summary form, dated 3/31/24 at 12:15 p.m., by CNA #1 revealed she observed Resident #3 at the nurses station with the DON and RN #3. The resident kept trying to get out of his wheelchair. CNA #1 observed the DON take the (Hoyer) straps, wrap them over his shoulders and hook them onto the handles of his wheelchair. The observations occurred around 3:00 p.m. CNA #1 said the position looked wrong, but she did not know what to do since it was her boss that did it. The NHA received a follow up call from the police officer (named) on 4/1/24 (not timed). The officer interviewed both the DON and RN #3. The DON admitted placing the (Hoyer) sling in such a position on the resident. RN #3 admitted she observed the DON placing Resident #3 in this position. III. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included malignant neoplasm of the prostate (prostate cancer), malignant neoplasm of the bladder (bladder cancer), intraspinal abscess with granuloma (abscess in the spine), acute/chronic respiratory failure with hypoxia and acute/chronic systolic (congestive) heart failure. The 6/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had no impairments in functional limitation in range of motion. The resident utilized a wheelchair. B. Record review The care plan for activities of daily living (ADL) self-care performance deficit was initiated on 3/29/24. The interventions included Resident #3 required the use of a wheelchair for mobility. The resident required two staff assistance by full body lift for staff to move between surfaces. The care plan did not reveal that the resident required a Hoyer lift for transfers. The care plan for actual impairment to the skin of the perineal area with abscess was initiated on 3/29/24. The interventions included using a draw sheet or lifting device to move the resident. -Review of Resident #3's electronic medical record (EMR) did not reveal any documentation regarding the incident on 3/30/24. IV. Staff Interviews CNA #1 was interviewed on 12/30/24 at 3:09 p.m. CNA #1 said a Hoyer lift was typically used to get Resident #3 out of bed and into his wheelchair. She said the resident was sitting on the lift sling and he was at the nurses station on 3/31/24. She said he was not in any pain and he was not yelling out. She said the straps from the sling were pulled between his legs over his shoulders and they were not attached to anything. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, her witness interview summary documented the Hoyer lift sling straps were attached to the resident's wheelchair handles. CNA #1 said this event occurred a long time ago and she could not remember if the sling was attached to the wheelchair handles. RN #1 was interviewed on a telephone conference call with the NHA on 12/30/24 at 5:04 p.m. RN #1 said she did not observe who placed the resident in this restraint position. She said a CNA called her at home and said the DON and RN #3 had used a Hoyer lift sling to tie the resident to his wheelchair. She said the CNA who called her did not witness who placed the resident in this position, however the CNA was told by other CNAs how the resident was positioned in his wheelchair by the Hoyer lift straps. She said she came to the facility and performed an assessment of the resident and to report the incident as an occurrence. She said it was in the middle of the night and close to midnight. She said the resident was already in bed, when she and another staff member conducted the assessment. RN #1 said the resident had no obvious injuries from being placed in the position that was described by the CNA. She said CNA #1 was one of the staff members who witnessed the resident being secured to his wheelchair with the Hoyer lift straps and told her of the event. RN #1 said she placed this statement in the occurrence that was sent to the State Agency. RN #1 said she notified the Board of Nursing and they started their own investigation of the event. RN #1 said, according to a police officer, the DON and RN #3 admitted tying the resident to the wheelchair to keep him from falling out of the chair. RN #1 said on 3/30/24, both the DON and RN #3 were suspended and on 4/3/24 they were both terminated from the facility. CNA #3 was interviewed on 12/30/24 at 10:15 p.m. CNA #3 said the resident was seated in his wheelchair at the nurses station. She said the resident was sitting on a lift (Hoyer) sling. She said the sling (split leg) and the straps were brought up between his legs, over his shoulders and attached to his wheelchair handles. She said he was in this position for a few hours. She said the resident did not appear to be in pain and was not yelling out. She said she did not know who placed the resident in this position. CNA #3 said she told the other staff members this was a restraint. She said when she took the resident to bed, she removed him from this position. She said the DON and RN #3 were working on that unit. She said to her knowledge, both the DON and RN #3 were aware of the resident being placed in this position. She said she had never seen the resident in this position before or after this event. RN #3, the NHA and the regional director of quality and compliance (RDQC) were interviewed together on 12/31/24 at 12:57 p.m. RN #3 said she and the DON were working at the nurses station. RN #3 said the staff used a Hoyer lift for transfers for Resident #3. She said the resident was confused and talking with people that were not there. She said he tried to stand up and slid out of the chair. She said he was at the nurses station and had a Hoyer lift sling under him. She said at one point in time the slings of the lift were brought up between his legs, the straps were under his arms and then attached to the handles of the wheel chair. She said she did not know who placed the straps in this position. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RDQC said the DON placed the straps in this position. The RDQC said the DON felt this was the safest position for Resident #3 to be placed in for his own safety. The RDQC said the resident had a history of sliding out of his wheelchair and falling related to a diagnosis of tuberculosis of the spine. The RDQC said the configuration of the straps was not for punishment nor convenience, but as a medical necessity to keep him from siding out of the chair and falling. The RDQC said Resident #3 did not incur any injuries from this positioning. The RDQC said the resident was sent to the hospital the next day related to increased hallucinations. The RDQC said both the DON and RN #3 were reprimanded and terminated. The RDQC said the investigation of the event was sent to the Board of Nursing. The RDQC said the Board of Nursing cleared RN #3 of any misconduct on 4/8/24. The RDQC said the police found there was no criminal intent by either the DON or RN #3. The RDQC said the CNAs who witnessed this event were given written warnings, in-serviced and re-educated on abuse. The RDQC said RN #3 was rehired at the facility because no actions were taken by the Board of Nursing and the police found no evidence of criminal intent. RN #3 was rehired, in-serviced and retrained on abuse. The RDQC said the DON was not rehired.

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F 0684 Level of Harm - 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** 50853 Based on record review and interviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for one (#4) of four residents out of 15 sample residents. Resident #4, who had diagnoses of type 2 diabetes mellitus with chronic kidney disease and foot ulcers, heart failure and osteomyelitis (infection of the bone) of the left ankle and foot, was admitted from the hospital on 9/16/24 with surgical wounds to both heels following surgical debridement (removal of dead tissue) of his diabetic wounds and placement of a wound vacuum (negative pressure wound therapy) on the left heel. Hospital discharge instructions included the resident was to be non-weight bearing to bilateral lower extremities and Prevalon boots (soft heel protection boots) were to be worn on both feet. However, the facility failed to enter physician's orders for Resident #4's non-weight bearing status or Prevalon boots into the resident's electronic medical record (EMR) upon the resident's admission to the facility. Additionally, the facility failed to include the use of Prevalon boots or Resident #4's non-weight bearing status on the skin and pressure ulcer care plan initiated on 9/17/24. Resident #4 began receiving weekly visits by the wound care physician on 9/18/24. However, documentation revealed the resident was not seen by the wound care physician on 10/1/24, 10/23/24, 11/6/24 and 11/26/24. The 11/20/24 wound care physician visit record revealed the wound on Resident #4's left heel had worsened and increased in size since the last visit on 11/13/24. Resident #4 declined sharp debridement (removing dead or unhealthy tissue) on 11/20/24 and the wound care physician removed the wound vacuum. The wound care physician changed the treatment order and planned to re-evaluate in one week. On 11/24/24 the nursing skin assessment documented Resident #4's left heel wound was improving without the wound vacuum, but had eschar (black, scab-like dead tissue) and a mild odor. There was no documentation the physician was notified of the eschar or odor. The wound care physician did not evaluate the resident's left heel wound on 11/26/24. The nurse documented completing the wound care on 11/26/24 but did not complete a skin assessment or wound progress note on 11/26/24. The nursing progress note dated 11/28/24 documented the left heel wound was described as having a blackened area to the wound bed and as having a foul odor. The wound care physician was contacted and recommended sending Resident #4 to the emergency department for treatment of a worsening wound. Findings include: I. Facility policy and procedure The Wound Care policy, dated 12/19/16, was provided by the regional director of quality and compliance (RDQC) on 12/31/24 at 2:28 p.m. It read in pertinent part, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Verify that there is a physician's order for treatment/wound care to be provided. Dress wounds in accordance with the physician's order. Notify the resident's attending physician if the resident refused wound care. Report other information in accordance with professional standards of practice. II. Resident #4 A. Resident status Resident #4, age 75, was admitted on [DATE] and discharged to the hospital on 11/28/24. According to the November 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with chronic kidney disease and foot ulcers, heart failure, atherosclerotic heart disease (plaque build-up in arteries), atrial fibrillation (irregular heart rhythm) and osteomyelitis of the left ankle and foot. The 9/19/24 minimum data set (MDS) assessment revealed the brief interview for mental status (BIMS) was not completed. However, a BIMS assessment was completed on 9/26/24 and Resident #4 had a BIMS score of 13 out of 15, indicating his cognition was intact. He required minimal assistance with bed mobility and maximum assistance with transfers. The assessment documented the resident had an infection of the foot, diabetic foot ulcers, other open lesions of the foot and surgical wounds. He had a pressure reducing device for his bed and wheelchair and he was not on a turning or repositioning program. The assessment documented the resident had an application of dressings to his feet (with or without topical medications). B. Record review Review of Resident #4's 9/16/24 hospital discharge instructions revealed the resident was to be non-weight bearing to bilateral lower extremities and Prevalon boots (soft heel protection boots) were to be worn on both feet. The skin and pressure ulcer care plan, initiated 9/17/24, revealed Resident #4 had the potential for altered skin integrity due to limited mobility, had moisture associated skin damage on the buttocks and groin and had open surgical wounds on both heels. Interventions included educating the resident on frequent repositioning, providing treatments per physician's orders and notifying the physician if wounds did not respond to treatment, encouraging good nutrition, monitoring for signs of infection (redness, warmth, odor, pain), providing wound consultation weekly and changing the wound vacuum every Wednesday and Saturday. -The care plan failed to include the use of Prevalon boots or Resident #4's non-weight bearing status. -The care plan did not include an intervention of an air mattress or a pressure reduction mattress (see physician's orders below). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #4's September 2024 CPO revealed a physician's order for an air mattress to the resident's bed, ordered 9/17/24. The physician's order did not include air mattress settings or checking to assure the mattress was working every shift. The physician's order was discontinued on 9/20/24. Review of Resident #4's November 2024 CPO revealed the following physician's orders: Change the wound vacuum to the left heel every Wednesday and Saturday, ordered 10/31/24, discontinued 11/12/24, restarted 11/14/24 and discontinued a second time on 11/20/24. Weekly skin checks on Tuesdays, ordered 9/16/24. -Review of Resident #4's October 2024 treatment administration record (TAR) revealed the resident's wound vacuum was not changed on 10/1/24. -There was no documentation to indicate the wound care physician was notified that the resident's wound vacuum was not changed or why it was not changed on 10/1/24. The 10/24/24 at 2:05 a.m. nurse progress note documented the resident refused to have the wound vacuum changed (on 10/23/24) because it was too late and the resident did not want it changed. -However, there was no documentation to indicate the resident's wound vacuum was changed on the following day or that the wound care physician was notified of the resident's refusal to have the wound vacuum changed. -Resident #4's November 2024 TAR revealed no documentation that the resident's wound vacuum was changed on 11/6/24 or 11/13/24. -There was no documentation to indicate the wound care physician was notified that the resident's wound vacuum was not changed or why it was not changed on 11/6/24 or 11/13/24. -Additionally, the November 2024 TAR revealed there was no documentation that weekly skin checks were completed for Resident #4 on 11/19/24 or 11/26/24. A 11/24/24 skin check assessment documented Resident #4's left heel wound was draining serosanguineous fluid (fluid that contains the liquid part of blood and blood and is generally clear/yellowish in color) and the wound edges had thick slough. There was a mild odor noted and eschar was present. -There was no documentation in Resident #4's EMR to indicate that the nurse notified the physician of the changes noted in the resident's left heel wound. Review of Resident #4's wound care physician consultations revealed the resident's left heel wound was not seen by the wound care physician on 10/1/24, 10/23/24, 11/6/24 and 11/26/24. Progress notes revealed the wound care physician was not available on 10/1/24, however, no alternate visit was scheduled. -There was no progress note documenting why the 10/23/24 wound care physician visit did not occur. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 11/6/24 wound care physician visit was cancelled due to bad weather and was not rescheduled. A 11/26/24 progress note revealed the wound care physician came to the facility on [DATE] but did not see any residents because there was not a facility nurse available to make rounds with the physician. The 11/20/24 wound care physician care visit note revealed the wound on Resident #4's left heel had worsened and increased in size from 4.5 centimeters (cm) in length by 4.7 cm in width by 0.2 cm in depth with 100% granulation (healing tissue) and no undermining (erosion under the skin) to 5.2 cm in length by 5. 5 cm in width by 0.2 cm in depth with 40% slough (refers to dead tissue within a wound, often appearing as a yellow, tan, or white fibrous material) and 60% granulation (healing tissue) with no eschar (hard scab-like tissue) and 0.6 cm undermining since the last visit on 11/13/24. Resident #4 declined sharp debridement (removing dead or unhealthy tissue) on 11/20/24 and the wound care physician removed the wound vacuum. The wound care physician changed the treatment order to cleanse the wound, apply oil immersion gauze to the wound bed, cover with one-half strength Dakin's solution (wound treatment solution used to prevent infection) soaked gauze and secure with an abdominal (ABD) pad (a highly absorbent, cushioning dressing), kerlix (rolled gauze bandage) and an elastic rolled bandage to secure the wound dressings three times per week. The wound care physician planned to re-evaluate in one week. The wound care physician recommended following up with podiatry if there was no improvement. The 11/26/24 nurse progress note documented the wound care physician was in the building but did not see residents because the facility's wound care nurse was not available to assist with wound rounds. Resident #4 was documented as being very upset because the wound care physician did not see him and the resident was worried his wounds were not healing. The nurse documented completing the wound care but did not complete a wound care progress note on 11/26/24. -There was no documentation in the EMR to indicate the wound care physician was notified that the resident was concerned his wound was not healing. The 11/28/24 nurse progress note documented Resident #4's left heel wound had a blackened area to the wound bed and was noted to have a foul odor. The wound care physician was contacted and the physician recommended sending Resident #4 to the emergency department for treatment of a worsening wound. III. Staff interviews The RDQC, the nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 12/31/24 at 12:07 p.m. The RDQC said Resident #4 was admitted on [DATE] after a two week acute hospital stay. The RDQC said the resident's heel wounds started as diabetic ulcers and the resident had surgical repair, including bone grafts, to both heels. The RDQC said there were inconsistencies in the medical record regarding whether the wounds were caused by pressure or diabetic ulcers. The RDQC said the resident's wounds were stable until approximately 11/8/24 when the resident started declining and wanted to change to comfort care. -However, Resident #4's left heel wound was not seen by the wound care physician on 10/1/24, 10/23/24 or 11/6/24 and the wound vacuum was not changed per the physician's orders on 10/23/24 (see record review above). (continued on next page)

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	065174	A. Building B. Wing	12/31/2024

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The RDQC said Resident #4 was wavering on whether to continue the wound vacuum and it was stopped for one day on 11/13/24 and returned to the rental company. The RDQC said the wound vacuum was initiated again on 11/15/24 until the wound care physician decided to discontinue it again on 11/20/24. The RDQC said she was unaware the wound care physician came to the facility on [DATE] and left without seeing residents. The RDQC said timeliness of weekly skin checks was part of a performance improvement plan (PIP) initiated by the facility on 10/15/24. The RDQC said the facility was still working on the accuracy of care plans. -However, despite the initiation of the 10/15/24 PIP, Resident #4's care plan was not updated to include the use of Prevalon boots or the resident's non-weight bearing status. Additionally, weekly skin assessments were not completed for the resident on 11/19/24 or 11/26/24 (see record review above). The DON said she knew the wound care physician was scheduled to visit on 11/26/24 but he was late and when he arrived, the facility did not have a nurse to make wound rounds with him. The DON said if the wound care physician was unavailable she would expect the nurses to do the wound rounds without the physician. The DON said nurses were to notify the wound care physician if there was a change in a resident's wound. The DON said weekly skin assessments should be documented in the EMR. The NHA said if the facility had identified any issues with Resident #4's weekly skin assessments in their audits and reported them to the QAPI committee in November 2024, he would provide the documentation. -There was no documentation indicating Resident #4's weekly skin assessments were discussed at the November 2024 QAPI meeting provided by the NHA by the survey exit on 12/31/24. IV. Additional information The NHA provided the facility's 10/15/24 PIP on 12/31/24 at 12:49 p.m. The PIP indicated resident care plans were to be reviewed and updated by 10/28/24. Weekly audits of skin assessments began on 10/24/24 and findings were to be reported to the quality assurance and performance improvement committee (QAPI) for 12 weeks. -However, Resident #4's care plan was not updated to include the use of Prevalon boots or the resident's non-weight bearing status. Additionally, weekly skin assessments were not completed for the resident on 11/19/24 or 11/26/24 (see record review above).

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injuries from occurring or worsening for one (#8) of four residents reviewed out of 15 sample residents. Resident #8, who was at risk for developing pressure ulcers and had a history of pressure ulcers, was admitted on [DATE] and readmitted to the facility on [DATE] after a three-day hospital stay. The readmission skin assessment, dated 11/6/24, documented the resident had a 1.0 centimeter (cm) by 1.0 cm scabbed area on his coccyx which the nurse covered with a foam dressing. However, there was no documentation that a treatment order was requested or that the facility's wound nurse or the wound care physician were notified of the skin concern. The 11/6/24 primary care physician's readmission history and physical examination documentation did not indicate Resident #8 had any current skin issues. The weekly nursing skin assessment, dated 11/13/24, documented Resident #8 had a reddened area to his coccyx measuring 1.0 cm by 1.0 cm and a foam dressing was applied for comfort. Again, there was no documentation that a treatment order was requested or that the facility's wound nurse or the wound care physician were notified of the skin concern. The 12/9/24 weekly nursing skin assessment documented Resident #8 did not have redness or any open area to his coccyx. However, the 12/16/24 weekly nursing skin assessment documented the resident had a 1. 0 cm round open area on his sacrum/coccyx. On 12/18/24 the wound care physician documented Resident #8 had an unstageable pressure injury to his sacrum measuring 1.6 cm by 1.5 cm by 0.2 cm in depth and covered with 100% slough (refers to dead tissue within a wound, often appearing as a yellow, tan, or white fibrous material). The wound care physician recommended treatment orders to cleanse the wound, apply Medihoney (wound treatment that prevents bacterial growth) and cover with a border gauze every other day and as needed. The facility failed to notify the wound care nurse and the wound care physician of the skin concern noted to Resident #8's coccyx upon his readmission to the facility and obtain appropriate physician's orders for treatment. Due to the facility's failures, the resident's skin concern developed into an unstageable pressure injury to his coccyx which increased in size from 1.0 cm by 1.0 cm on 11/6/24 to 1.6 cm by 1.5 cm by 0.2 cm by the time the resident was assessed by the wound care physician on 12/18/24. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved on 1/2/25 from https://www. internationalguideline.com/guideline on, Pressure ulcer classification is as follows: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure The Prevention of Pressure Ulcers/Injuries policy, dated 12/19/16, was provided by the regional director of quality and compliance (RDQC) on 12/31/24 at 2:28 p.m. It read in pertinent part, Newly identified skin impairments should be reported by the licensed nurse to the attending physician to obtain new treatment orders. Routine skin assessments should be performed by the licensed nurse after admission in accordance with the physician's order. III. Resident #8 A. Resident status Resident #8, age less than 65, was admitted on [DATE], discharged to the hospital on 11/3/24 and readmitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included bipolar disorder, generalized anxiety disorder, cerebral palsy (a neurological disorder affecting the ability to move, maintain balance and control muscles), hypomagnesemia (low magnesium) and chronic pain syndrome. The 9/29/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was independent or required minimal assistance with bed mobility and dressing and was independent with transfers. The assessment indicated the resident was at risk of developing pressure ulcers. B. Resident interview and observation Resident #8 was interviewed on 12/30/24 at 11:34 a.m. Resident #8 was sitting in his wheelchair. There was no specialty air mattress on his bed. He said he had a sore on his bottom that was caused at the facility because they gave him a new wheelchair cushion that was too hard and thin. Resident #8 pointed out the wheelchair cushion lying near his roommate's dresser. Resident #8 said he was now using his old wheelchair cushion which was thicker and softer. Resident #8 said he had a history of a sore, open to the bone, on his bottom but it was healed. Resident #8 said he should have had a dressing put on the wound on his bottom this morning (12/20/24) after his shower, but the nurse kept putting it off. He said he did not currently have a protective dressing on his bottom. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/30/24 at 12:15 p.m. Resident #8 was lying in bed and prepared for wound care by RN #2. Resident #8 did not have a dressing covering the wound. RN #2 cleansed and measured the wound. The wound was covered in yellow slough and measured 1.3 cm by 1.0 cm. C. Record review The skin care plan, initiated 10/17/19 and updated 11/13/24, documented Resident #8 had the potential for skin issues related to limited mobility, with the goal to maintain clean and dry skin through the next review date. -The care plan documented the resident had a history of several pressure ulcers but did not indicate a current pressure injury was present. Care plan interventions included doing skin checks weekly (which he frequently refused), encouraging the resident to lie down during the day to relieve pressure to the coccyx (which he frequently refused), ensuring adequate protein and nutritional intake, observing wound healing (he sometimes removed wound dressings) and providing a pressure relieving cushion in his wheelchair. An update to the care plan interventions was added on 11/13/24 and documented Resident #8 had pain to the tailbone, the area was reddened, and the nurse applied a foam dressing. -However, there was no documentation in Resident #8's electronic medical record (EMR) to indicate the wound care physician was notified or a treatment order was obtained. The December 2024 CPO documented the following physician's orders: Weekly skin checks on Wednesdays, ordered 11/12/24. Cleanse sacrum/coccyx wound, apply Medihoney and cover with a border gauze every other day and as needed, ordered 12/18/24. Review of Resident #8's November 2024 and December 2024 treatment administration records (TAR) indicated the resident refused the weekly skin check on 11/20/24 but no other weekly skin checks were refused by the resident. The readmission skin assessment, dated 11/6/24, revealed Resident #8 had a dry, scabbed over area on the coccyx. The 11/6/24 readmission nursing progress note documented the resident had intact skin except for a 1.0 cm by 1.0 cm area on the coccyx. No further description of the skin concern was documented. -There was no documentation in the resident's EMR to indicate that a treatment order was requested or that the facility's wound nurse or the wound care physician were notified of the skin concern. The weekly nursing skin assessment, dated 11/13/24, documented Resident #8 had a reddened area to his coccyx measuring 1.0 cm by 1.0 cm and a foam dressing was applied for comfort. -There was no documentation in the resident's EMR to indicate that a treatment order was requested or that the facility's wound nurse or the wound care physician were notified of the skin concern. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 12/9/24 weekly nursing skin assessment documented Resident #8 did not have redness or any open area to his coccyx. The 12/16/24 weekly nursing skin assessment documented the resident had a 1.0 cm round open area on his sacrum/coccyx. The nurse documented a change of condition progress note for the physician but there were no recommendations from the physician documented. The 12/18/24 wound care physician documentation revealed Resident #8 had a 1.6 cm length by 1.5 cm width by 0.2 cm depth unstageable pressure injury to the sacrum covered in 100% slough. The wound care physician recommended treatment orders to cleanse the wound, apply Medihoney and cover with a border gauze every other day and as needed. IV. Staff interviews Registered nurse (RN) #2 was interviewed on 12/30/24 at 12:25 p.m. RN #2 said Resident #8 had a shower that morning (12/20/24) at 6:30 a.m. RN #2 said she got busy and was not able to do his wound care and apply the protective dressing following the resident's shower. -Resident #8 did not have a protective wound dressing covering his wound from 6:30 a.m. until 12:15 p.m., almost six hours. The director of rehabilitation (DOR) was interviewed on 12/31/24 at 9:38 a.m. The DOR said she provided a new wheelchair cushion for Resident #8 within the past four weeks. The DOR said Resident #8 kept his previous wheelchair cushion in case he did not like the new one, but she was not aware he did not like it and was not using the new cushion. The RDQC was interviewed on 12/31/24 at 12:07 p.m. The RDQC said a performance improvement plan (PIP) was initiated on 10/15/24 for pressure ulcers. The RDQC said the facility was still working on the accuracy of care plans. -Despite the initiation of the 10/15/24 PIP, Resident #8's care plan was not updated to include the resident's current unstageable pressure injury to his coccyx (see record review above). The director of nursing (DON) was interviewed on 12/31/24 at 12:25 p.m. The DON said a round 1.0 cm open area was found on Resident #8's sacrum on 12/16/24. The DON said Resident #8 had a history of not sleeping in his bed even though staff encouraged him to lie down. The DON said Resident #8 was not using an air mattress because it made it difficult for him to transfer in and out of bed independently. The DON said she was not aware Resident #8 had any skin impairment issues on his coccyx or sacrum prior to 12/16/24. The DON said when the nurse identified Resident #8's skin issue to his coccyx on 11/6/24, the nurse should have notified the physician and requested treatment orders. The DON said the nurses should have notified the wound nurse and communicated the skin issues on the 24-hour report so the resident could have been seen by the wound care physician timely. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The DON said Resident #8 should have had a protective dressing covering the wound on his sacrum as soon as possible after his shower on 12/30/24. The DON said she added a physician's order on 12/31/24 for as needed dressing changes for the nurses to document replacing Resident #8's dressing after showers or when soiled. The nursing home administrator (NHA) was interviewed on 12/31/24 at 12:35 p.m. The NHA said Resident #8 received the new wheelchair cushion from the therapy staff on 12/4/24. The NHA said he was not aware Resident #8 was unhappy with the new cushion. V. Additional information The NHA provided the facility's 10/15/24 PIP on 12/31/24 at 12:49 p.m. The PIP indicated care plans were to be reviewed and updated by 10/28/24. The PIP documented the nurses were provided education beginning 10/24/24 on procedures to follow for any new skin issues identified. When a new skin issue was identified, the nurses were to do alert charting for 72 hours, notify the physician and request treatment orders. -However, Resident #8's care plan was not updated to include the resident's current unstageable pressure injury to his coccyx (see record review above). -Despite the nursing education documented on the PIP, Resident #8's skin issue, identified on 11/6/24, was not reported until 12/16/24 and treatment orders were not received until 12/18/24.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50853 Based on observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. Specifically, the facility failed to: -Ensure wound care supplies were placed on a clean field; -Ensure a clean barrier was placed under the wound; -Ensure gloves were changed and hand hygiene performed during wound care; -Ensure each wound was cleaned and treated separately; and, -Ensure enhanced barrier precautions (EBP) were used during wound care. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC) Hand Hygiene in Healthcare Settings, updated 2/27/24, retrieved from https://www.cdc.gov/clean-hands/hcp/clinical-safety on 1/2/25, the following were recommendations for hand hygiene in healthcare settings: Clean your hands immediately before touching a patient, before performing an aseptic task such as placing an indwelling device or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces and immediately after glove removal. According to the CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), was retrieved on 1/6/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. II. Facility policy and procedure The Enhanced Barrier Precautions policy, revised 4/1/24, was provided by the regional director of quality and compliance (RDQC) on 12/31/24 at 2:28 p.m. It read in pertinent part, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement enhanced barrier precautions for individuals with chronic wounds such as pressure ulcers, diabetic foot ulcers or surgical wounds. In addition to the use of standard precautions, staff should wear gloves and a gown during high-contact resident care activities including wound care. The Wound Care policy, dated 12/19/16, was provided by the RDQC on 12/31/24 at 2:28 p.m. It read in pertinent part, Use a disposable barrier to establish a clean field on the resident's overbed table or other flat surface. Place all items to be used during the procedure on the clean field. Position the resident. Place a disposable barrier next to the resident, (under the wound) to serve as a barrier to protect the bed linen and other body sites. III. Observations On 12/30/24 at 12:15 p.m. registered nurse (RN) #2 was providing wound care for Resident #8's pressure ulcer on his coccyx. RN #2 placed the wound care supplies on the resident's bed, directly on the sheet. RN #2 donned (put on) gloves and assisted Resident #8 to turn onto his side. RN #2 did not put on a gown. RN #2 cleansed the wound and obtained measurements. Resident #8 was unable to maintain his position on his side and rolled back onto the bed, causing his wound to touch the incontinence brief that he was wearing. RN #2 assisted Resident #8 back onto his side and applied Medihoney (wound treatment) to the wound with a cotton applicator, while wearing the same gloves that she had cleansed the wound with. RN #2 said she needed to label the border gauze dressing, removed her soiled gloves, borrowed a pen from the roommate and wrote the date on the clean dressing. RN #2 donned clean gloves without performing hand hygiene. RN #2 applied the border gauze dressing to the wound, removed her gloves and performed hand hygiene. RN #2 told Resident #8 he needed his incontinence brief changed and assisted him to put on a clean incontinence brief. -RN #2 did not prepare a clean field to place supplies on; -RN #2 did not follow EBP and don a gown prior to performing wound care; -RN #2 did not place a clean barrier on the bed, under the resident's wound; -RN #2 did not change gloves after cleansing the wound and before applying medication to the wound; and, -RN #2 did not perform hand hygiene after she removed her soiled gloves and before donning clean gloves and handling the clean dressing. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/24 at 2:52 p.m. the infection preventionist (IP) was providing wound care for Resident #10's pressure ulcer on his left heel and an open wound caused by gout on his third toe of the right foot. The IP placed a disposable barrier on the floor under Resident #10's feet, performed hand hygiene and donned clean gloves. The IP did not put a gown on prior to starting wound care. The IP cleansed the wound on the third toe of the right foot and then cleansed the wound on the heel of the left foot heel. Without changing gloves, the IP applied the treatments and dressings to the wounds. -The IP did not follow EBP and don a gown prior to performing wound care; -The IP did not change gloves after cleansing the wounds and before applying treatment to the wounds; and, -The IP did not treat each wound separately. IV. Staff interviews RN #2 was interviewed on 12/30/24 at 12:25 p.m. RN #2 said she should have performed hand hygiene after removing her soiled gloves and before putting on clean gloves to apply the dressing. RN #2 said she usually did not change her gloves after cleansing a wound, unless her gloves were visibly soiled. RN #2 said she did not put down a clean field for wound care supplies unless she was doing a sterile dressing change. The IP was interviewed on 12/30/24 at 3:00 p.m. The IP said she should have changed her gloves between wounds and treated each wound separately. The IP said she should have changed her gloves after cleaning the wound and before applying the treatment and the clean dressing. The director of nursing (DON) was interviewed on 12/31/24 at 12:25 p.m. The DON said EBP should be followed when providing wound care. The DON said the IP and RN #2 should have donned a gown and gloves before they provided wound care. The DON said when wound care was provided, a clean field should be set up for supplies and clean barrier should be placed under the wound. The IP said soiled gloves should be removed and hand hygiene performed after cleaning the wound and before applying a new dressing. The DON said if there was more than one wound, each wound should be treated separately to prevent cross contamination.