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	02/03/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review and interviews, the facility failed to prevent verbal abuse for one (#5) of seven residents reviewed for abuse out of 14 sample residents. Specifically, the facility failed to ensure Resident #5 was free from verbal abuse from Resident #6. Findings include: I. Facility policy and procedure The Abuse Policy, revised 6/11/24, was provided by the regional nurse consultant (RNC) on 1/27/25 at 1:31 p.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 would take every precaution to prevent resident abuse. All occurrences of resident abuse, suspected abuse, neglect and injuries of unknown source would 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 or enabled through use of technology or social media. Verbal abuse was the use of oral, written or gestured language that included disparaging or derogatory terms to residents or within their hearing distance, regardless of their ability to comprehend. The facility would ensure that 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 event that caused the allegation involved abuse or resulted in serious bodily injury; or not later than 24- hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and Adult Protective Services (APS) where state law provided jurisdiction in long term care facilities and office of long term care ombudsman) in accordance with state law through established procedures. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All employees of the facility would 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 administrator's designee. The administrator served as the abuse coordinator of the facility. The facility permitted the administrator or the administrator's designee to report suspected crimes or allegations of abuse to law enforcement, the State Survey Agency, and/or APS in place of the staff member who witnessed the suspected crime or reported the allegation of abuse. The director of nursing (DON) or designee would ensure that the medical director and resident representative (as applicable) was 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, would conduct an investigation of the alleged incident. The administrator or designee would interview any staff members, residents, family members or any others who might have knowledge of the incident and document a summary of interviews completed. The administrator or designee would 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 was substantiated, the appropriate corrective action would be taken. The facility would ensure that all residents were protected from physical and psychosocial harm during and after abuse investigations, including but not limited to, responding immediately to protect the alleged victim, examining the alleged victim for any sign of injury, including a physical examination and/or psychosocial assessment as indicated, increased supervision of the alleged victim and other residents as indicated, room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator, protection from retaliation and provide emotional support and/or counseling to the resident during and after the investigation as needed. Residents with aggressive or abusive behaviors would have their care plans written and revised as needed to include approaches to reduce or eliminate the risk for abuse. If one resident jeopardized the safety of another resident, alternative placement might be considered for that resident. II. Incident of verbal abuse between Resident #5 and Resident #6 on 1/1/25. The facility's incident report for verbal aggression, dated 1/1/25 at 8:35 a.m., revealed Resident #6 was yelling obscenities at Resident #5. No physical altercations occurred. The floor nurse immediately intervened and stopped the altercation. Resident #6 was asked to leave the shared room. Resident #6 went back into the room six times and starting yelling at Resident #5. Resident #6 reported being upset because of a shared television. Resident #6 was offered to move rooms and accepted. Resident #5 denied being fearful of Resident #6. Resident #5 stated that she was very upset with the way she was spoken to during the verbal altercation. Resident #5 said that her roommate, Resident #6, was fighting with her over the television channel. Resident #6 was moved out of the shared room, until the staff could decide where the resident could be moved to a different room. No injuries were observed on either resident. The nursing home administrator (NHA) and the director of nursing (DON) were notified and both residents were put on 15-minute checks for 72 hours. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing home administrator (NHA) provided typed documentation of the interviews that he conducted on 1/1/25 (no time given). The document revealed the NHA interviewed Resident #5 who said she wanted to finish her television show but Resident #6 wanted to watch another show. Resident #6 argued with Resident #5 but then left the room. Resident #6 continued to come into the room and escalated the conversation. Resident #6 got upset with Resident #5, insulted her by calling her obscenities and pointed her finger at Resident #5. Registered nurse (RN) #1 and some certified nurse aides (CNA) went in to console Resident #5 as she was crying and said she would rather go to her grave. The NHA interviewed Resident #6 who said she asked to watch a television show and Resident #5 wanted to continue to watch her television show. Resident #6 got upset when Resident #5 did not want to change the television show. Resident #6 requested to change rooms. The NHA interviewed RN #1. RN #1 said Resident #5 and Resident #6 were arguing about the television. RN #1 tried to find a compromise but was unable to find one. When the situation between the residents escalated, RN #1 asked Resident #6 if she would come to the nurse's station while a solution could be found. The NHA summarized that the residents were arguing about the television. Resident #6 wanted to watch a television program but Resident #5 wanted to finish the program that she was watching. Both residents starting arguing, which resulted in Resident #5 crying and Resident #6 requesting to have her own room. Resident #6 was immediately given her own room, which alleviated her television frustrations. Mental health services were offered to both residents. The facility concluded that Resident #6 yelled at Resident #5. III. Resident #5 - victim A. Resident status Resident #5, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2025 computerized physician's orders (CPO), diagnoses included schizoaffective disorder, depression, anxiety and metabolic encephalopathy. The 12/2/24 minimum data set (MDS) assessment documented the resident had intact cognitive ability with a brief interview for mental status (BIMS) score of 15 out of 15 with no behaviors. The resident had no impairments in functional ranges of motion. The resident was independent in sit to stand with the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. The resident was also independent with chair/bed-to chair transfers and had the ability to transfer to and from a bed to a chair (or wheelchair). B. Resident interview Resident #5 was interviewed on 1/28/25 at 2:07 p.m. Resident #5 said Resident #6 wanted to change the television channel and she did not want her to change the channel to a news station. She said Resident #6 was not yelling at her but only wanted to change the television channel. She said she had no concerns with Resident #6. C. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5's care plan for the potential to be physically aggressive, verbally aggressive and accusatory related to a history of swatting and yelling at staff was initiated on 11/18/23 and revised on 11/5/24. The interventions included providing the resident with positive feedback. The resident escalated toward verbal aggression when staff wanted to wash her clothes, asking about personal hygiene and dentures. The resident's behaviors were de-escalated by calmly walking away, not arguing with the resident, changing the subject and talking about something else. Resident #5's care plan for impaired cognitive function related to developmental delays from birth was initiated on 11/4/23. The interventions included for staff to observe/document/report as needed any changes in cognitive function, specifically, changes in decision-making ability, memory, recall, general awareness, difficulty expressing self, difficulty understanding others, level of consciousness and/or mental status. The resident would maintain her current level of decision-making ability by the review date. The staff were to cue, reorient and supervise the resident as needed. The staff were to communicate with the resident/family/caregivers regarding the resident's capabilities and needs. A care plan for a pre-admission screening resident review (PASRR) Level II related to the resident meeting the criteria for major mental illness (MMI) with a primary diagnosis of schizoaffective disorder, depressive type was initiated on 4/30/24. The interventions included allowing the resident to answer questions and to verbalize her feelings, perceptions and fears as needed, encouraging the resident to participate in non-pharmacological interventions based on interests, evaluating the resident's cognitive abilities for participation in recommended services and notifying the physician of any changes. The resident had signed up for behavioral health services for medication management with counseling, which she refused. A care plan, initiated on 1/1/25, revealed to monitor Resident #5 for any signs or symptoms related to verbal abuse for 90 days. The interventions included engaging the resident to express her feelings and monitoring/reporting any signs or symptoms of trauma, such as heightened emotions, to a nurse immediately. A nurse note, dated 1/1/25 at 1:17 p.m. and written by RN #1, revealed she heard a verbal altercation between Resident #5 and her roommate (Resident #6). Resident #5 was watching a television show and Resident #6 began yelling at Resident #5 to change the channel on the television. Resident #6 was using profanities/obscenities at Resident #5. After Resident #5's television show was over, she turned the television to the channel Resident #6 wanted to watch. Resident #6 started yelling at Resident #5 again for not turning the volume up on the television. The television was quite loud when RN #1 entered the room a second time. Resident #6 was asked to leave the room and sat outside of the shared room. RN #1 walked away from the residents' room. About three minutes after RN #1 walked away from the area, Resident #6 went back into the shared room and started yelling at Resident #5 again. RN #1 went into the room and removed Resident #6 from the room, to the nurse's station. The NHA interviewed all that were involved in the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse note, dated 1/1/25 at 8:35 a.m. and written by the DON, revealed it was reported that Resident #6 was yelling obscenities at Resident #5. No physical altercation occurred. The floor nurse (RN #1) immediately intervened. Resident #6 reported being upset because of a shared television. Resident #6 was offered to move rooms and accepted. Resident #5 denied being fearful of Resident #6. The DON, the NHA, the social service director (SSD) and the floor nurses were notified and were to monitor the residents. A psychological follow up note, dated 1/2/25 at 9:00 a.m. and written by a nurse practitioner (NP), reiterated RN #1's note on 1/1/25 at 1:17 p.m. It further revealed Resident #5 had good eye contact and was guarded. The resident was depressed and anxious. The resident had appropriate thought processes and associations were logical. The resident had no hallucinations, suicidal ideations or homicidal ideations. A physician's note, dated 1/2/25 at 7:49 p.m., revealed nursing reported that there was resident to resident conflict and that Resident #5 was a victim of verbal abuse by another resident. Resident #5 initially said that she did not want to live but nursing said she had improved since yesterday (1/1/25) when the incident happened. Resident #5 no longer felt that she would be better off dead. IV. Resident #6 - assailant A. Resident status Resident #6, age greater than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included depression, major depression, polyneuropathy, anxiety and chronic pain syndrome. The 12/6/24 MDS assessment documented the resident had intact cognition with a BIMS score of 15 out of 15 with no behaviors. The resident had little interest or pleasure in doing things. The resident felt down, depressed or hopeless. The resident was independent with indoor mobility (ambulation). The resident needed some staff help with functional cognition (planning regular tasks). B. Resident interview Resident #6 was interviewed on 1/28/25 at 3:41 p.m. Resident #6 said she did not want to discuss the verbal altercation involving Resident #5. C. Record review Resident #6's care plan for a mental health diagnosis of depression that required the use of an antipsychotic was initiated on 12/11/24. The interventions included administering medications as ordered, monitoring for any side effects and notifying the physician of any adverse or consistent side effects that occurred related to the use of a psychotropic medication, documenting target behaviors each shift, notifying a physician of any new/worsened symptoms of mental illness that were not effectively managed with current pharmacological and non-pharmacological interventions and the psychotropic committee would review the resident's medication regimen, target symptoms/side effects at least quarterly and make recommendations as indicated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6's care plan for the potential to be verbally aggressive related to a diagnosis of depression and anxiety was initiated on 1/1/25. The interventions included administering medications as ordered, monitoring/documenting any side effects/effectiveness of medications, behavioral health consults as needed and assisting the resident in developing and providing the resident with a program of activities that was meaningful and of interest. The staff were to encourage and provide opportunities for exercise and physical activity. A nurse note, dated 1/1/25 at 1:17 p.m., and written by RN #1, revealed she heard a verbal altercation between Resident #6 and her roommate (Resident #5). Resident #5 was watching a television show and Resident #6 began yelling at Resident #5 to change the channel on the television. Resident #6 was using profanities/obscenities at Resident #5. After Resident #5's television show was over, she turned the television to the channel Resident #6 wanted to watch. Resident #6 started yelling at Resident #5 again for not turning the volume up on the television. The television was quite loud when RN #1 entered the room a second time. Resident #6 was asked to leave the room and sat outside the shared room. RN #1 walked away from the residents' room. About three minutes after RN #1 walked away from the area, Resident #6 went back into the shared room and started yelling at Resident #5 again. RN #1 went into the room and removed Resident #6 from the room, to the nurse's station. The NHA interviewed all that were involved in the incident. A nurse note, dated 1/1/25 at 8:35 a.m. and written by the DON, revealed it was reported that Resident #6 was yelling obscenities at Resident #5. No physical altercation occurred. The floor nurse (RN #1) immediately intervened. Resident #6 reported being upset because of a shared television Resident #6 was offered to move rooms and accepted. Resident #5 denied being fearful of Resident #6 The DON, the NHA, the SSD and the floor nurses were notified and were to monitor the residents. A follow up note dated 1/2/25 at 7:55 p.m., by a physician revealed this resident was verbally abusive to another resident (her roommate) yesterday. They have since been separated. An event note template, dated 1/3/25 at 9:13 a.m., revealed Resident #6 was verbally aggressive towards another resident (Resident #5). The risk factors/root cause was the television channel. The resident had a diagnosis of major depression disorder and was in a new environment. The residents were separated and provided independent rooms. V. Staff interviews RN #1 was interviewed on 1/28/25 at 1:17 p.m. RN #1 said she was conducting a medication pass and heard a verbal altercation between Resident #5 and Resident #6. Resident #6 was yelling at Resident #5 because she wanted to watch a news channel and Resident #5 wanted to finish watching the program currently on the television. She said there was only one television in the room. She said Resident #6 was yelling foul names and profanities at Resident #5. RN #1 said she asked Resident #6 to step out of the room and talk with the staff. RN #1 said Resident #6 stepped out of the room and she thought the incident had been settled. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 said she continued with her medication administration. She said Resident #6 went back into the room and started yelling at Resident #5 about the volume on the television. RN #1 said she went into the room and asked Resident #6 to leave the room a second time. She said Resident #6 came out of the room and sat down near the nurse's station. She said Resident #6 sat at the nurse's station for about 30-45 minutes to drink a cup of coffee and talk with staff. RN #1 said Resident #5 became very emotional after being verbally attacked by Resident #6. Rn #1 said Resident #6 was told that she would be moved to another room and she was okay with this decision. She said once the residents were in separate rooms, staff started 15-minute checks on both residents. RN #1 said Resident #5 never said she was fearful of Resident #6. The RNC and the DON were interviewed together on 1/28/25 at 4:19 p.m. The RNC said it was reported that Resident #5 and Resident #6 got into a verbal altercation because Resident #6 wanted to watch a news channel. The RNC and the DON said they did not witness any of the altercations. The RNC and the DON said, to their knowledge, this was the first and only altercation between the two residents The NHA was interviewed on 1/29/25 at 10:21 a.m. The NHA said Resident #5 and Resident #6 had a verbal disagreement. He said to his knowledge, this was the first and only altercation between the two residents. The NHA said after the altercation, he came into the facility and started doing interviews of those involved in the incident.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review and interviews, the facility failed to provide the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being for one (#4) of seven residents reviewed for behavioral and emotional status out of 14 sample residents. Specifically, the facility failed to coordinate timely necessary behavioral, mental and emotional health care and services for Resident #4 after the resident expressed suicidal ideation. Findings include: I. Resident #4 A. Resident status Resident #4, age greater than 65, was admitted on [DATE] and discharged to home on 1/23/25. According to the January 2025 computerized physician orders (CPO), diagnoses included alcohol abuse with withdrawal, dementia, psychotic disturbance, mood disturbance, anxiety and hemiplegia and hemiparesis following a cerebral infarction that affected the right dominant side. The 12/30/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. The assessment indicated the resident had no behaviors. The assessment indicated the resident had no thoughts that she would be better off dead or of hurting herself in some way, did not feel down, depressed or hopeless and did not have little interest or pleasure in doing things. B. Record review The admit/readmit screener form, dated 12/26/24 at 2:55 p.m., revealed Resident #4 was admitted from the hospital. The form did not reveal the resident had depression or any behaviors. The resident's baseline care plan for social services, dated 12/27/24, revealed the resident had a history of alcohol dependence combined with a diagnosis of dementia. There was a significant concern with suicidal ideation, depression and anxiety. The interventions included frequent checks for 72-hours, referral to the emergency room for a psychological evaluation and referral to behavioral health services for psychological treatment. The care plan also revealed the pertinent initial care plan focus statement, goals and interventions related to mental health needs: the resident had mental health (diagnosis/diagnoses) of (SPECIFY) and requires the use of (SPECIFY: anti-depressant, anti-anxiety, antipsychotic, sedative/hypnotic, mood stabilizer). (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility failed to develop Resident #4's social services baseline care plan to specify the resident's mental health diagnosis/diagnoses or what medications the resident's mental health diagnosis/diagnoses required for treatment. Additional interventions included administering medication per physician's order, monitoring for side effects and notifying the physician of any adverse or consistent side effects that occurred related to psychotropic drug use, staff were to document target symptoms each shift and notify the physician of any new/worsened symptoms of mental illness that were not effectively managed with current pharmacological and non-pharmacological interventions. If the resident's mental health symptoms became unmanageable in-house or a mental health crisis occurred, staff were to call the crisis line or notify the physician to obtain transfer orders for a psychiatric evaluation in the hospital setting and the psychotropic committee would review medication regimen, target symptoms and side effects at least quarterly and make recommendations as indicated. A Colorado Suicide Lethality Screening Tool (CSLST), dated 1/1/25 at 5:54 p.m., revealed in the past weeks, Resident #4 wished she was dead. In the past weeks, the resident felt she or her family would be better off if she was dead. In the past weeks, the resident had thoughts about killing herself. The resident was currently having thoughts of killing herself right now. The resident told a licensed practical nurse (LPN) that she wished she was dead and if she had a gun, she would shoot herself and if she had a knife, she would stab herself. -There was no documentation in Resident #4's electronic medical record (EMR) to indicate the resident was placed on increased monitoring or that the resident's physician, the nursing home administrator (NHA) or the director of nursing (DON) were notified of the resident's suicidal ideation after the CSLST was completed on the evening of 1/1/25 and identified that the resident expressed wanting to kill herself. The Healthcare Resident Safety Plan was signed by the resident on 1/1/25 (no time documented). The purpose of the safety plan was to identify triggers/warning signs the resident might experience during a mental health crisis. It was also used to remind the resident of helpful activities and people that could help keep the resident safe, if the resident experienced a mental health crisis. A social services note, dated 1/2/25 at 10:00 a.m., revealed Resident #4 was placed on frequent checks for 72 hours. A nurse note, dated 1/2/25 at 10:12 a.m., revealed the resident's primary care physician (PCP) was notified of the resident's suicidal ideations and the PCP would evaluate the resident during today's (1/2/25) rounding. -Review of Resident #4's EMR did not reveal documentation of the 15-minute checks. An eINTERACT situation, background, assessment and recommendations (SBAR) summary for providers note, dated 1/2/25 at 1:44 p.m. by Resident #4's physician, revealed the resident had a change in condition. Nursing observations, evaluations, and recommendations revealed the resident said if she had a way to kill herself, she would. The resident made mention of a gun, knife and pills. The resident said the only thing that was stopping her, was that she had nothing (to help her commit the act). The PCP recommended sending the resident to the emergency room (ER) at the hospital for evaluation and treatment. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse note, dated 1/2/25 at 2:25 p.m., revealed Resident #4 was sent to the ER for evaluation and treatment related to recent ideations of self-harm. A call was made to the ER and a report was provided. The resident said that if she had a gun she would shoot herself and if she had a knife, she would stab herself. Resident #4 said if she had medication available, she would take it all. A non-emergent ambulance was called and given the same report. The non-emergent ambulance arrived and left the building at 2:35 p.m. The resident's physician and power of attorney (POA) were notified according to the DON and the social services director (SSD). -The facility failed to send Resident #4 to the ER for a mental health evaluation until almost 24 hours after the resident initially expressed wanting to kill herself. The ER report revealed Resident #4 arrived at the hospital on 1/2/25 at 2:44 p.m., by ambulance. The resident was brought to the ER by emergency medical services (EMS) for an evaluation of depression and verbalizing possible suicidal thoughts. The resident said, on Christmas Eve, she did not have any visitors and was not allowed to participate in the holiday party at the facility. This occurred again on New Year's Eve and she became very depressed. However, she was currently feeling better and did not feel like she wanted to hurt herself. When asked what she would like, she said she wanted to go back to her room at the facility and get into her bed. The resident was discharged from theER on [DATE] at 3:07 p.m., with education materials for depression. A nurse note, dated 1/2/25 at 3:48 p.m., revealed Resident #4 returned to the facility with no new orders. The resident was alert and had no pain or discomfort. The resident made no further ideations. A skilled charting note, dated 1/2/25 at 7:24 p.m., revealed Resident #4 had not made any further ideations of self-harm after returning from the ER. The resident was alert and able to make her needs known. The resident was mobile with the use of a wheelchair. The resident was resting in bed. A history and physical note, dated 1/2/25 at 7:56 p.m. and written by Resident #4's physician, revealed the resident reported suicidal ideations today (1/2/25) to the nursing staff. The resident said if she had a way to kill herself, she would, regardless of the method. The facility sent the resident to the ER for evaluation. The ER physician called this physician and reported that the resident's mood had improved, she was no longer suicidal and the resident wanted to come back to the facility. -However, Resident #4 had reported suicidal ideations to the facility staff on 1/1/25, not 1/2/25 (see above). A physician's order, dated 1/4/25 at 3:40 p.m., revealed to administer Sertraline HCl oral tablet 25 milligrams (mg), one tablet by mouth once a day for anxiety. -The physician's order was not obtained until 1/4/25, three days after Resident #4 expressed wanting to kill herself. (continued on next page)

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	065174	A. Building B. Wing	02/03/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's baseline care plan for social services, locked on 1/6/25, revealed the resident had mental health needs/behavioral concerns for behavioral health services following suicidal ideations. The interventions to address mental health needs/behavioral concerns were for frequent monitoring. The care plan also revealed the pertinent initial care plan focus statement, goals and interventions related to mental health needs: the resident had a mental health diagnosis of major depressive disorder and required the use of an antidepressant. The interventions further revealed if the resident's mental health symptoms became unmanageable in-house or a mental health crisis occurred, staff were to call the crisis line or notify the physician to obtain transfer orders for a psychiatric evaluation in the hospital setting. Staff were to obtain informed consent for the use of psychotropic medication. The medication regimen included black box warnings that would be reviewed in each care conference meeting. The psychotropic committee would review medication regimen, target symptoms and side effects at least quarterly and make recommendations as indicated. The baseline care plan for social services further revealed the staff should use the following non-pharmacological interventions to help manage the resident's behavioral symptoms of: (SPECIFY symptoms/behaviors that resident displays) (SPECIFY). Additional interventions were to provide opportunities for socialization, provide encouragement, support and active listening, provide reality orientation if appropriate, do not provide reality orientation if the resident was unable to be oriented to reality or it was distressing to the resident and avoid resident's triggers: (specify). -The facility failed to develop Resident #4's social services baseline care plan to specify the symptoms/behaviors the resident displayed that staff should use non-pharmacological interventions for or what the resident's triggers for the behaviors were. A comprehensive care plan focus for Resident #4's history of suicidal ideations was initiated on 1/6/25. The interventions included a behavioral health service referral was to be completed, having a safety plan and suicide contract in place, staff would monitor and manage any undesirable behaviors, if the resident posed a potential threat to injure herself or others, the staff were to notify her provider, if the resident was safe, staff was to allow the resident personal space and if the resident wandered or paced, staff were to initiate visual supervision during the acute episode. -However, there was no documentation in Resident #4's EMR to indicate the facility referred the resident for behavioral health services. Additional interventions included staff were to maintain a consistent schedule with daily rounding, minimize the resident's environmental stimuli, monitor for cognitive, emotional or environmental factors that might contribute to violent behaviors, monitor the resident for signs/symptoms of agitation, offer the resident acceptable alternatives to unacceptable situations, provide clear, simple instructions, provide reorientation to situations and provide verbal feedback to the resident regarding behaviors. -The facility failed to initiate a comprehensive care plan focus for suicidal ideations until 1/6/25, five days after the resident expressed wanting to kill herself. An interdisciplinary team (IDT) event note template, dated 1/6/25 at 9:44 a.m., revealed Resident #4 had suicidal ideations on 1/2/25. The root cause was the resident had a recent hospitalization and a history of alcohol use. The ER physician had cleared the resident from harm/ideations and the new intervention was to refer the resident for behavioral health services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, Resident #4 had reported suicidal ideations to the facility staff on 1/1/25, not 1/2/25 (see above). -Additionally, there was no documentation in Resident #4's EMR to indicate the facility referred the resident for behavioral health services. A care conference summary note, dated 1/7/25 at 11:40 a.m., revealed Resident #4 was in attendance and had no nursing or medication concerns. The resident said she had frequent discomfort (pain). The Psychological Assessment, dated 1/9/25 at 10:37 a.m., revealed Resident #4's cognition was moderately impaired. The resident did not require assistance with communicating. The resident had significant trouble adjusting to the facility upon admission but had since adjusted appropriately. The resident had alcohol abuse with severe withdrawals. The resident's psychological factors included mental health conditions, trauma, post-traumatic stress disorder (PTSD), substance abuse, behavioral issues, self-efficacy deficits, and lack of coping skills. The resident's social factors included lack of social support, strained family relationships, social isolation, desire for community involvement, desire for physical/sexual intimacy while in the facility and sexual identity concerns. The resident had diagnoses that included dementia, alcohol abuse, major depressive disorder, anxiety, suicidal ideation, isolation, tearfulness, and suicidal ideation by informing some staff of the ideation while denying the ideation to others. -The facility failed to conduct a Psychological Assessment until 1/9/25, eight days after the resident expressed wanting to kill herself. II. Staff interviews The activity director (AD) was interviewed on 1/27/25 at 10:34 a.m. She said Resident #4 attended the New Year's Eve party on 12/31/24 at 1:30 p.m. She said the resident only stayed at the party for about five minutes and did not mention any suicidal ideations. The SSD was interviewed on 1/27/25 at 11:07 a.m. She said Resident #4 told her, on 1/2/25, that she was actively suicidal, if she had a way to complete the act. She said the resident completed and signed the Healthcare Resident Safety Plan on 1/1/25 (not time documented). She said by signing the safety plan, Resident #4 acknowledged that she would not kill herself. She said the resident's physician assessed the resident on 1/2/25 and completed his note at 7:56 p.m. She said the resident was placed on frequent checks that were documented on a form. She said the resident also had an order for a referral to go to theER on [DATE]. The SSD said she was not made aware of the resident's lethality assessment until the morning of 1/2/25. She said if the lethality assessment was conducted, she should have been notified and if the resident was suicidal, she should have been notified immediately. -However, the facility was unable to provide documentation of the 15-minute checks. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #2 was interviewed on 1/27/25 at 11:28 a.m. LPN #2 said she interviewed Resident #4 and completed the Colorado Suicide Lethality Screening Tool (CSLST) on 1/1/25 at 5:54 p.m. She said she searched the resident's room for any type of item that the resident could use to harm herself and nothing was found. She said after the CSLST was completed, the staff rounded on the resident more often. LPN #2 said the resident stayed in her room and slept on and off. She said when the resident woke up, she was in a better mood. She said she started the resident on 15-minute checks and parked the medication cart by the resident's entrance door, so she could watch the resident. She said she told the oncoming registered nurse (RN) #2 for the next shift about the resident's suicidal ideations and handed RN #2 the 15-minute check form. She said she was very busy and did not call the DON or the NHA. She said she told additional staff and the DON about the resident's statements the next day, on 1/2/25. -However, the facility was unable to provide documentation of the 15-minute checks. The regional nurse consultant (RNC) and the DON were interviewed together on 1/27/25 at 11:41 p.m. The DON said she first became aware of Resident #4's suicidal ideations during the 1/2/25 morning meeting. She said after she saw the CSLST, she called the resident's physician at 10:12 a.m. The DON said the frequent checks started when she saw the CSLST. She said frequent checks did not have to be 15-minute checks that were documented on a form. The DON said Resident #4's physician assessed the resident and gave the order to send the resident to theER on [DATE] at 1:43 p.m. She said when staff used the CSLST, she should be notified that the form was used, regardless of the outcome on the form. She said she was not notified that the CSLST had been used to assess Resident #4 and she was not made aware of its findings after it had been completed. RN #1 was interviewed on 1/27/25 at 12:11 p.m. RN #1 said on 1/1/25 at approximately 10:30 a.m., Resident #4 was down the hall and she heard the resident mention suicidal ideations. She said she brought the resident to the nurse's station for one-to-one supervision. She said Resident #4 sat at the nurse's desk for a few hours and did not make any additional comments. She said the resident said she was not happy with her care. RN #2 was interviewed on 1/27/25 at 12:40 p.m. RN #2 said she came to work on 1/1/25 and during the report meeting, LPN #2 said Resident #4 had suicidal ideations and wanted to kill herself. RN #2 said she filled out the 15-minute check form, starting at 1/1/25 at 6:30 p.m. She said the 15-minute check form was continued until there were no more lines on the form. She said she filed the form in a folder at the nurse's station, for the possibility of the checks starting the next day. She said Resident #4 never told her of any suicidal ideations. She said the resident wanted coffee and Tylenol all during the night. She said the next day (1/2/25), LPN #2 came back to work and she already knew what the resident had said. The DON and LPN #2 were interviewed together on 1/27/25 at 1:50 p.m. LPN #2 said she was providing direct supervision of Resident #4 by placing her medication cart outside the resident's room and looking in on the resident during medication administration. She said when she came back to work the next morning, RN #2 did not give her the 15-minute check form. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said when a resident expressed suicidal ideations, the resident's physician should be notified and the resident should be placed on one-to-one supervision. The DON said the physician would provide a crisis assessment and/or possibly send the resident to the ER for a mental health assessment. The DON said Resident #4's physician did an assessment on the resident on 1/2/25 and decided he wanted to send the resident to the ER. The DON said the resident was not sent to the ER immediately on 1/1/25, because she was not aware of the resident's statements until the morning meeting on 1/2/25. The social services director (SSD) was interviewed again on 1/29/25 at 10:31 a.m. The SSD said from the time the resident entered the facility on 12/26/24 to 1/1/25, the resident had not exhibited any behaviors. She said she completed the Colorado Suicide Lethality Screening Tool (CSLST) on 1/1/25 for Resident #4. She said after the resident returned from the ER, she denied having any more suicidal ideations. The minimum data set coordinator (MDSC) was interviewed on 1/29/25 at 10:45 a.m. The MDSC said Resident #4's baseline care plan was developed on 12/27/24 and was updated and locked on 1/6/25. She said the admit/readmit screener assessment, dated 12/26/24 at 2:55 p.m., did not mention that the resident had depression or any behaviors. She said the first progress note to mention the resident had behaviors and was on frequent checks was on 1/2/25. She said the resident went to theER on [DATE] and the intervention for the behavioral health services for psychological treatment was on 1/6/25 at 9:44 a.m. The RNC and the SSD were interviewed together on 1/29/25 at 12:01 p.m. The RNC and the SSD said Resident #4 was assessed on admission and had no behaviors until she made the statement of suicidal ideation on 1/1/25. The RNC and the SSD said the resident was on skilled services and staff did a daily nurse assessment on the resident which included monitoring of cognition and mood/behaviors. The RNC and the SSD said until 1/1/25, there was no mention of any behaviors for Resident #4 in the nurse notes. The RNC said before the resident's suicidal ideation statement on 1/1/25, the facility's corporate office had provided training to all the social workers on psychosocial topics and this had been an ongoing process. The RNC said additional audits had been conducted at the facility to review resident progress notes for changes in condition, psychotropic medication orders and PASRR (pre-admission screening and resident review), and five selected residents' daily progress notes were audited for dignity. The RNC said the facility looked to see if any residents had suicidal ideations and if the facility responded appropriately.