STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065174	A. Building B. Wing	04/07/2025

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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review and interviews, the facility failed to update the admissions agreement so it did not waive the facilities liability for loss of resident's personal property for one (#3) of two residents out of nine sample residents. Specifically, the facility failed to ensure Resident #3 did not waive her rights for reimbursement for the loss of personal property (five rings) during her stay in the facility. Findings include: I. Facility policy and procedures The Resident Personal Belongings policy, dated 2024, was provided by the nursing home administrator (NHA) on 3/25/25 at 12:48 p.m. The policy revealed this facility protected the resident's right to possess personal belongings, such as clothing and furnishings, for their use while in the facility. The facility would ensure that personal belongings and/or possessions were rightfully returned to the resident, or to the resident's representative, in the event of the resident's death or discharge from the facility. The facility would support the resident's right to retain and use personal possessions to promote a homelike environment and maintain their independence. All resident personal items would be inventoried at the time of admission by the social services designee, or another designated staff member and documentation shall be retained in the medical record. Additional possessions brought in during the duration of the individual's stay should be added to the existing personal belongings inventory listing. The facility would support the resident's right to retain and use personal possessions to promote a homelike environment and maintain their independence. All resident personal items would be inventoried at the time of admission by the social services designee, or another designated staff member and documentation should be retained in the medical record. Additional possessions brought in during the duration of the individual's stay should be added to the existing personal belongings inventory listing. Following the discharge or death of a resident, all personal clothing and items of a customized personal nature were to be given to the designated resident representative. Inventories of all items were to be reviewed and examined by the Social Services designee and the resident's representative. Recipients of such personal items at the time of discharge or death should sign-off with their legal signature, acknowledging receipt of all personal belongings presented. II. Resident #3 (continued on next page)

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

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

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #3, age greater than 65, was admitted on [DATE] and discharged on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses diabetes mellitus, chronic systolic (congestive heart failure), post-procedural, infection/inflammation due to cardiac and vascular devices, implants and/or grafts. The 10/7/24 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 required substantial/maximal staff (staff did more than half of the effort by lifting or holding the trunk or limbs and provided more than half of the effort) assistance for toileting. The resident required partial/moderate staff (staff did less than half of the effort by lifting, holding or supporting the trunk or limbs less than half of the effort) assistance for upper and lower body dressing. B. Record review Resident #3 signed the Standard Admission Agreement on 10/3/24. The agreement revealed the facility was not responsible for the theft, misplacement, loss or damage otherwise incurred to the resident's personal property and the facility would not be responsible for the repayment or replacement of personal property. Resident #3's admission personal belongings inventory form, dated 10/3/24, revealed the resident entered the facility with five rings. This form was signed by the resident and a registered nurse (RN). The form explained to the resident that all items retained in the resident's possession were the responsibility of the resident. The facility assumed no responsibility for lost or damaged items. A grievance report form, dated 10/31/24, submitted by the resident and their legal representative revealed at discharge the resident reported not having her five rings. One of the rings was her wedding ring. The admission personal belongings inventory form confirmed the resident had five rings on admission. The steps taken to resolve the grievance revealed the staff searched all the rooms the resident resided in during her stay and were unable to locate the rings. The resident and family told facility staff that they would search all of the resident's personal belongings once they got home. The resident and family would let the facility know if they were able to find the rings. On 11/18/24 the facility received a message from the family and they were unable to locate the missing rings. The corrective action portion of the form revealed the facility reported the missing rings as an occurrence related to misappropriation of property on 11/18/24. An event note dated 11/19/24 at 10:00 a.m., revealed it was reported on 11/18/24 by a family member of Resident #3 that the resident was missing five rings that the family was not able to locate. Resident #3 discharged to home on 11/1/24. The risk factors and root cause identification revealed the resident tested positive for a COVID-19 infection during her stay at the community. The resident changed rooms twice during her stay. The resident was encouraged to use the secured lockbox to safeguard her valuables but the resident chose not to. The preventative measures in place prior to the incident revealed the resident discharged home with her family on 11/1/24. Upon admission, residents were being informed and encouraged to use secured to the wall lockboxes that were in each residents' rooms. The new interventions put in place were upon admission, residents were being informed and encouraged to use secured to the wall lockboxes located in residents' rooms. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Staff interviews RN #1 was interviewed on 3/25/25 at 4:05 p.m. She reviewed Resident #3's admission personal belongings inventory form, dated 10/3/24, and agreed that the resident had five rings listed on the form. She said she completed the discharge summary with Resident #3 when she was discharged from the facility. RN #1 said this included the discharge personal belongings inventory form. She said the resident did not have the five rings at discharge. RN #1 said the resident told her the rings were in a plastic bag. She said to her knowledge the plastic bag containing the five rings was never located. She said she made a copy of the discharge personal belongings inventory form and gave it to the resident. She said the facility was unable to find this form. The SSD was interviewed on 3/26/25 at 9:55 a.m. The SSD said she reviewed the Admission Agreement form with the resident and/or their representative. She said she also asked them if they have any questions about the agreement. She said the agreement explained to the residents that personnel property brought into the facility; the facility was not liable for if it were damaged, missing or stolen. She said the residents were encouraged to keep their valuables locked up and they were offered a metal lock box with a key for their room. The NHA and the regional director of operations (RDO) were interviewed on 3/26/25 at 10:18 a.m. The NHA said the facility was trying to find a compromise with the family regarding the missing five rings. The NHA said according to the admission personal belongings inventory form dated 10/3/24, the resident had five rings upon admission. He said the facility had contacted the family and requested an appraisal or a receipt for the rings. He said the resident had a lock box in the rooms that she resided in during her stay in the facility. He said the facility was unable to find the discharge personal belongings inventory form and asked the family to provide a copy of the form to the facility. The NHA was interviewed again at 12:24 pm. He said the family told the facility the five rings were worth $3,000.00 dollars. The NHA said he asked the family for at least a description of the rings.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 48458 Based on record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (#6) of five residents out of nine sample residents. Resident #6 was admitted to the facility on [DATE] with diagnoses of right leg above the knee amputation, left arm paralysis following stroke, peripheral vascular disease (reduced blood flow to limbs), dysphagia (difficulty swallowing), respiratory failure and diabetes. On [DATE] at 6:20 a.m. Resident #6 told the certified nurse aides (CNA) he was experiencing shortness of breath. The CNAs observed the resident was experiencing shortness of breath and informed licensed practical nurse (LPN) #1 of the resident's significant change in condition. LPN #1 failed to collect information regarding Resident #6's condition, notify a registered nurse (RN) to conduct a complete physical assessment of the resident or report Resident #6's concern and significant change in condition to a physician. Resident #6 was later found unresponsive and not breathing. Resident #6 expired at the facility on [DATE] at 9:00 a.m. The facility failed to ensure staff promptly identified and intervened appropriately when Resident #6 experienced a significant change in condition, which resulted in a situation of serious harm. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on [DATE] to [DATE], resulting in the deficiency being cited as past noncompliance with a correction date of [DATE]. I. Situation of serious harm On the morning of [DATE] at 6:20 a.m. Resident #6 reported a change of condition (shortness of breath) to the CNAs. The CNAs observed Resident #6's shortness of breath and conveyed the resident's concern and status to LPN #1. LPN #1 failed to collect information regarding Resident #6's condition, notify a RN to conduct a complete physical assessment of the resident or report Resident #6's concern and significant change in condition to a physician. Resident #6 was later found unresponsive and not breathing. Resident #6 expired at the facility on [DATE] at 9:00 a.m. The facility began an investigation immediately following the incident on [DATE]. LPN #1 was suspended on [DATE] following the incident, and terminated from employment at the conclusion of the facility's investigation. II. Facility's plan of correction The corrective action plan implemented by the facility in response to Resident #6's change of condition failure on [DATE] was provided by the regional director of operations (RDO) on [DATE] at 8:30 a.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The stated purpose of the plan was the facility's immediate action plan to remove the likelihood that serious harm to a resident would occur or recur. The plan revealed the following: 1. Identification of residents affected or likely to be affected. The facility took the following actions to address and prevent any additional residents from suffering an adverse outcome: (Completion date: [DATE]). -The DON or designee notified the facility medical director of the incident. -Nursing supervisors/designees completed physical assessments/interviews on all residents to identify any changes in condition and notification was made to the physician of any noted changes. Concerns were not identified. -The DON suspended the licensed nurse who was aware of significant change, but did not report it to the physician, pending investigation. 2. Actions to prevent occurrence/recurrence- The facility took the following actions to prevent an adverse outcome from reoccurring: (Completion date [DATE]). -The licensed nurse was terminated on [DATE]. She remained on suspension from [DATE] until termination on [DATE]. -All licensed nurses were educated by the DON/designee on appropriate addressing of urgent changes of condition, physician notification regulations, and facility policy and procedure. -Nurse aides were educated by the DON/designee on escalating resident changes in condition to other licensed nurses in the facility if they do not receive an adequate response from the nurse assigned to the patient. -Staff members were not permitted to work a shift until education was completed. -New hires (licensed nurses and nurse aides) will be educated on change of condition and physician notification regulations, as well as facility policy and procedure, accordingly in orientation by human resources/designee. -The DON implemented a Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) with a focus on physician notification of significant changes. -The PIP resulted in implementation of five times/week DON/designee audits of the 24-hour report and conducting nursing staff huddles to monitor for change in resident condition. -The DON/designee will also complete chart audits as follows, three residents weekly for four weeks then two residents weekly for two weeks then two residents a month for two months. -The regional consultant nurse will visit the facility two times per month to provide general oversight and monitoring of the PIP. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date facility asserts likelihood for serious harm no longer exists: [DATE]. III. Facility policy and procedure The Change in a Resident's Condition or Status policy, revised February 2021, was provided by the RDO on [DATE] at 4:04 p.m. It read in pertinent part, The nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. A significant change in condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); impacts more than one area of the resident's health status; requires interdisciplinary review and/or revision to the care plan; and ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the eInteract Change of Condition evaluation form. IV. Facility investigation of incident on [DATE] and education provided in response to incident The facility's plan of correction/performance improvement plan (PIP) binder was provided by the RDO on [DATE] at 8:30 a.m. The binder included a documented interview of LPN #1 which occurred on [DATE]. It read in pertinent part, The nurse reports that she checked on the resident (Resident #6). She said he seemed normal and she measured his oxygen saturation level (level of oxygen in the blood), which read 92% (percent). She admits she did not listen to his heart, lungs, ask him questions, obtain a full set of vital signs (temperature, heart rate, blood pressure and respiratory rate), complete additional assessment or notify the physician. A description of the facility's education and inservice training documents conducted in response to the incident were included in the PIP binder. The documentation included the following, in pertinent part: Interventions that were put into place to help prevent a recurrence: Education as done with all nurses and CNAs prior to their next scheduled shift to ensure they understand policies and procedures regarding resident complaints of acute symptoms. This education was provided by the DON and the ADON (assistant director of nursing) and included a post-education quiz for nurses. CNAs were educated to always report to their nurse the residents' complaints and to escalate the complaint to another nurse, the DON/NHA if their complaint was not properly addressed by their nurse. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Additionally, beginning the week of [DATE] and ongoing, all nurses will be evaluated for competency in performing head-to-toe evaluations by the DON/designee. The medical director will conduct additional training with nursing staff related to response to resident changes in condition. New nursing staff will receive this education during orientation. Audits are in place to ensure residents who are experiencing a change of condition have proper follow up. The results of the audits will be reviewed by the QAPI (quality assurance and performance improvement) committee. The [DATE] nursing assessment training document included signed verification of training for 15 nursing staff members. The [DATE] inservice training document for change of condition education provided by the medical director included signed verification of training for 46 facility staff members. Review of 24-hour report audits and resident chart audits revealed the DON audits had been completed through [DATE]. The education record (prior to [DATE]) for LPN #1 was provided by the RDO on [DATE] at 3:40 p.m. It revealed the following: LPN #1 had attended an inservice education regarding residents' change of condition a year prior to the incident, on [DATE]. The inservice education read in pertinent part, A change in a resident's condition may mean that he or she is at risk. Action can be taken only if changes are noticed and reported, the earlier the better. Changes that are not reported can lead to serious outcomes, including medical complications, transfer to a hospital or even death. V. Resident #6 A. Resident status Resident #6, age less than 65, was admitted on [DATE] and expired at the facility on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included right leg above the knee amputation, left arm paralysis following stroke, peripheral vascular disease, dysphagia, respiratory failure and diabetes. The [DATE] minimum data sets (MDS) assessment revealed the resident was cognitively intact with a brief interview of mental status (BIMS) score of 14 out of 15. He required set up assistance with eating, substantial assistance with hygiene and dressing and was dependent on staff for toileting and showering. B. Record review Review of Resident #6's February 2025 CPO revealed the resident had a physician's order indicating the resident was to be a do not resuscitate (DNR) status, ordered [DATE]. Review of Resident #6's Medical Orders for Scope of Treatment (MOST) form, signed on [DATE], revealed the following: -Resident #6 did not wish to receive cardiopulmonary resuscitation (CPR); (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He wished to have selective treatment, which included using intravenous (IV) antibiotics and IV fluids, if indicated, and to transfer to the hospital, if indicated, but avoid intubation and intensive care; and, -The resident wished to receive artificial nutrition by tube for short term/temporary only. A review of Resident #6's electronic medical record (EMR) revealed the following progress notes: A nurse progress note, dated [DATE] at 7:33 p.m., documented Resident #6 was complaining of pain in his left shoulder. The ADON was notified and asked to go visit with him. Resident #6 told the ADON staff rolled him too far on his left side Sunday ([DATE]) and it made his left shoulder pop with pain. Resident #6 was repositioned in bed for comfort control. The ADON asked the nurse to call the PA (physician's assistant). The nurse told the PA about Resident #6's complaint and the PA said she saw the resident yesterday ([DATE]) but he never mentioned his shoulder pain. The PA ordered an MRI (magnetic resonance imaging) of the resident's left shoulder. Resident #6 was encouraged to take Tylenol routinely for pain management prior to initiating something stronger. A nurse progress note, dated [DATE] at 12:30 p.m., documented, a nurse spoke with Resident #6 regarding his MRI and when it would be scheduled. The nurse informed the resident that the physician's order had been faxed to central scheduling and the facility was awaiting a call back. When the nurse entered the resident's room, the resident was moving his fan with his right hand and said his fingers were numb and he could not grab with them. The nurse reported the findings to the nurse practitioner (NP). The NP said it was not an emergent situation. Resident #6 was offered lidocaine patches which he refused. Resident #6 accepted a physical therapy (PT) evaluation and the facility would obtain a MRI as soon as it was scheduled. A nurse progress note, dated [DATE] at 6:30 a.m. and written by LPN #1, documented a CNA reported that Resident #6 was having a difficult time breathing. LPN #1 checked the resident a few minutes later and Resident #6 was breathing at his baseline, with no shortness of breath noted. Resident #6's oxygen saturation level was 92% on room air. Resident #6 did open eyes and said hey to LPN #1. A nurse progress note, dated [DATE] at 7:59 a.m. and written by the DON, documented a CNA contacted the DON and said that Resident #6 was not breathing. Upon assessment, the resident was noted with no heartbeat, breaths or blood pressure. The DON called the resident's representative. The DON attempted to call the representative four times with no answer. The coroner was contacted and Resident #6 was pronounced deceased at 9:00 a.m. Multiple more attempts were made to contact the resident's representative with no answer. Review of Resident #6's vital signs documentation revealed the following: -On [DATE] at 1:41 p.m., the resident's temperature was 97.0 degrees fahrenheit (F); -On [DATE] at 1:41 p.m., the resident's respiration rate was 18 breaths per minute; -On [DATE] at 1:41 p.m., the resident's pulse was 80 beats per minute (bpm); -On [DATE] at 1:41 p.m., the resident's blood pressure was ,d+[DATE] millimeters of mercury (mm/Hg); (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On [DATE] at 1:41 p.m., the resident's oxygen saturation was 92% on room air; -On [DATE] at 9:23 p.m., the resident's pulse was 87 bpm; and, -On [DATE] at 9:23 p.m., the resident's blood pressure was ,d+[DATE]. -Review of Resident #6's EMR did not reveal that a full set of vital signs was obtained on the resident on the morning of [DATE]. VI. Staff interviews The NP was interviewed on [DATE] at 1:00 p.m. The NP said she ordered an ultrasound to evaluate Resident #6's right hand on [DATE], and later changed the order on [DATE] to an MRI of his hand for nerve impingement. The NP said sometimes MRI scheduling could take longer in rural locations, and the resident was still waiting for the MRI procedure when he expired. The NP said she was at the facility the day prior to his death. She said she did not examine him at the time, but was told he had the same symptoms on his right side (from [DATE]), including numbness of his right wrist with decreased grip strength. She said he had no new or acute pain on his left side. The NP said Resident #6's roommate at the time said Resident #6 asked a staff person to go to the hospital the day he expired ([DATE]). She said she was not certain if the staff person was LPN #1. The NP said there should have been an immediate call to the provider when Resident #6 said he wanted to go to the hospital, was short of breath or said he could not breathe. The NP said Resident #6 had a do not resuscitate order and the DON called her when he expired and she pronounced his death. CNA #4 was interviewed on [DATE] at 3:07 p.m. CNA #4 said when she arrived for her shift at 6:00 a.m. on [DATE] and received report, the previous CNA told her and CNA #5 that Resident #6 was not feeling well during the night and was awake and used his call light a lot. CNA #4 said she and CNA #5 entered Resident #6's room at 6:20 a.m. ([DATE]) and the resident said he was not feeling well. She said she and CNA #5 observed Resident #6 could not catch his breath, so she elevated the head of his bed and informed LPN #1 of Resident #6's shortness of breath. CNA #4 said LPN #1 did not respond or acknowledge either of the CNAs when they told her of the resident's change in condition. CNA #4 said she repeated the information to LPN #1 and LPN #1 again did not respond to her. CNA #4 said after she reported the information to LPN #1, she and CNA #5 monitored Resident #6's room to see if LPN #1 went to evaluate the resident. She said they did not see LPN #1 enter Resident #6's room. CNA #4 said Resident #6's roommate put his call light on at approximately 7:00 a.m. and told her Resident #6 needed assistance. She said Resident #6 said he felt like he was having a stroke and could not breathe. CNA #4 said she told LPN #1 of Resident #6's statements again at 7:09 a.m. and LPN #1 again did not acknowledge or reply to CNA #4's statements. CNA #4 said LPN #1 just looked at me. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA #4 said she continued to work together with CNA #5 to assist residents who were getting up for the day. CNA #4 said another CNA (CNA #6) checked on Resident #6 at approximately 7:20 a.m. and told her that he was breathing and appeared to be sleeping. CNA #4 said an additional CNA arrived to work at 7:50 a.m. and CNA #4 asked the CNA to check on the resident. CNA #4 said the CNA checked on Resident #6 and then called out to the DON and said the resident was cold and not breathing. CNA #4 said she had worked with LPN #1 before and LPN #1 never responded to her verbally. She said she and other CNAs were educated after the event with Resident #6 and instructed to go up the chain of command by contacting a registered nurse (RN) or the DON, whether it was day or night, if a nurse did not respond to a resident's change of condition or to their concerns. Resident #6's former roommate, who no longer resided at the facility, (Resident #11) was interviewed on [DATE] at 3:35 p.m. Resident #11 said Resident #6 was not feeling well during the night ([DATE]) and was having difficulty breathing in the morning hours of [DATE]. Resident #11 said he yelled for help several times and the call light was on for an extended period of time. Resident #11 said Resident #6 slowly drifted off after 7:30 a.m. Resident #11 said Resident #6 always had some problems with breathing, but that day it got really bad. Resident #11 said nobody was in the room when Resident #6 died . CNA #5 was interviewed on [DATE] at 12:06 p.m. CNA #5 said Resident #6 was not acting like his usual self and she was told in the shift report that he might be very tired, as he was uncomfortable and awake a lot during the night. CNA #5 said Resident #6 said he could have been having a stroke and she reported this information to LPN #1 and LPN #1 did not respond. CNA #5 said she probably would have told another nurse, but she was concerned that LPN #1 would get back at me. CNA #5 said she thought LPN #1 would ask her to do vital signs, including checking Resident #6's temperature, blood pressure, heart rate and respiratory rate. CNA #5 said LPN #1 did not ask her to do this. CNA #5 said it was possible LPN #1 did go into the resident's room, however, she said she never saw LPN #1 in Resident #6's room. CNA #6 was interviewed on [DATE] at 11:02 a.m. CNA #6 said she was a CNA on a different unit that day ([DATE]), however, she said she stopped over to the nurses station on Resident #6's unit. CNA #6 said CNA #4 and CNA #5 asked CNA #6 to check on Resident #6. CNA #6 said she stood next to the resident for a few minutes and he was breathing, did not appear to be short of breath and appeared to be sleeping. RN #1 was interviewed on [DATE] at 12:41 p.m. RN #1 said she was working when Resident #6 expired. She said she did not know he was having issues or had passed away until after it happened. RN #1 said she had been told LPN #1 should have responded to the CNAs concerns and told her about Resident #6's shortness of breath. RN #1 could not recall who told her this. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065174	A. Building B. Wing	04/07/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN #2 was interviewed on [DATE] at 10:43 a.m. RN #2 said she worked the three nights before Resident #6 expired. RN #2 said she remembered asking Resident #6 if he wanted her to send him to the hospital due to his continued right arm pain and he declined. RN #2 said Resident #6 had complained of right arm pain for a month and was scheduled to have a MRI. RN #2 said Resident #6 did not complain of left shoulder or arm pain on the last night before he expired ([DATE]). RN #2 said after she had given report to the oncoming nurse (on [DATE]), she overheard CNAs tell LPN #1 that Resident #6 was sick to his stomach. RN #2 said she had told LPN #1 in report the resident wanted arthritis cream in more locations than he usually did. She said Resident #6 refused his insulin that night, as he often did. RN #2 said she asked LPN #1 about Resident #6's condition before she left the building and LPN #1 said he was fine. CNA #7 was interviewed on [DATE] at 12:49 p.m. CNA #7 said Resident #6 was a little off that night ([DATE]). She said he could not sleep and was using the call light for things he usually could handle. CNA #7 he could not grab the bar for turning as well as he usually did and it required one more person for repositioning him. She said he was in more pain than usual and became angry, so she told RN #2 about this and RN #2 went to see the resident. CNA #7 said Resident #6 did not complain or appear to have shortness of breath and did not ask to go to the hospital. She said the resident did ask when his MRI was scheduled. The DON and the RDO were interviewed together on [DATE] at 2:06 p.m. The DON said she had arrived at the facility on [DATE] and was called to the resident's room when he expired. She said an investigation was started immediately and she discovered LPN #1 did not respond appropriately to Resident #6's complaints, including his shortness of breath. The DON said Resident #6 did not have any concerning symptoms the day before (on [DATE]) beyond existing right hand numbness/weakness which was ongoing for several weeks, of which the NP was aware. The DON said LPN #1 did not collect data from Resident #6 that was needed to assess the situation. The RDO said LPN #1 should have elevated the concern to a RN and reported the resident's condition change to the provider. The RDO said the CNAs should have reported the concerns to another floor nurse on duty if they were not getting a response from LPN #1. The DON said there were no complete assessments or RN assessments documented in Resident #6's record after he began experiencing a change of condition. She said a RN assessment of the resident should have been conducted. The DON said there was negligence on the part of LPN #1 as she did not collect all of the appropriate information or notify the RN and provider of the resident's change of condition. The DON said the CNAs were educated after the incident with Resident #6 and now understood to go up the chain of command (report to another nurse and the DON) as needed if a resident's concerns were not addressed. The DON said all nursing staff completed nurse competencies regarding change of condition response, including assessment and notification to providers following the incident.