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	08/20/2025

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 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** 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 two (#4 and #52) of five residents reviewed for pressure injuries out of 45 sample residents. Resident #4, who was at risk for developing pressure ulcers, was admitted on [DATE] and readmitted on [DATE] after a five-day hospital stay. The 4/2/25 wound weekly observation assessment revealed the resident acquired a right heel suspected deep tissue injury (DTI) on 3/21/25, three days after she was readmitted to the facility. The right heel wound measured 3.5 centimeters (cm) in length, 3.5 cm in width and 0.0 cm in depth. The assessment revealed it was the first observation of the wound. The initial treatment orders on 3/22/25 included floating the right heel with a pressure relief boot at all times. -However, the treatment to float the right heel was discontinued on 4/24/25. There was no further documentation to reveal why the treatment order was discontinued or what other offloading measures were added to prevent the pressure ulcer from worsening.On 6/18/25, the wound care physician (WCP) reclassified Resident #4's right heel wound as a stage 3 pressure injury. The right heel wound measured 1.1 cm in length, 1.5 cm in width, and 0.4 cm in depth.On 7/29/25 the WCP documented preventative measures for the resident included heel protectors and wedges.-However, observations during the survey revealed Resident #4 did not have her right heel consistently offloaded in order to prevent the pressure wound from worsening (see observations below).Additionally, Resident #52, who had a DTI to his left heel and a stage 3 coccyx pressure ulcer, did not receive timely interventions to prevent the potential for the development of further pressure wounds, and the facility failed to document the resident's weekly skin check assessments accurately.Specifically, the facility failed to:-Ensure appropriate wound prevention interventions were initiated and consistently implemented in order to prevent further potential pressure injuries from occurring and to promote healing for Resident #4, who had a stage 3 facility-acquired pressure ulcer;-Ensure timely pressure ulcer interventions were implemented after Resident #52 developed a DTI on 6/10/25 and a stage 3 coccyx pressure ulcer on 8/12/25;-Ensure physician's orders for Resident #52's stage 3 coccyx pressure ulcer were obtained in a timely manner after the wound was identified; and,-Ensure Resident #52's weekly skin check assessments were accurate.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 8/25/25 from https://www.internationalguideline.com/guideline, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when (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 0686 Level of Harm - Actual harm Residents Affected - Few	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 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. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	II. Facility policy and procedure The Pressure Injury Prevention and Management policy, dated 4/11/25, was provided by the nursing home administrator (NHA) on 8/20/25 at 5:04 p.m. It read in pertinent part, Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (for example moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to, redistributing pressure such as repositioning, protecting and or offloading heels; minimizing exposure to moisture and keeping the skin clean, especially of fecal contamination; providing appropriate, pressure-redistributing support surfaces; providing non-irritating surfaces; and maintaining or improving nutrition and hydration status, where feasible. Interventions will be documented in the care plan and communicated to all relevant staff. III. Resident #4 A. Resident status Resident #4, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included dementia, fracture of the unspecified part of the neck of the left femur, and pressure-induced deep tissue damage of the right heel. According to the 7/9/25 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had an impairment on one lower extremity and required a wheelchair. The resident required set up assistance with eating and oral hygiene. The resident required maximal assistance with showering and personal hygiene. The resident was dependent on rolling left and right, sitting to lying, lying to sitting and sitting to standing. The assessment revealed the resident was at risk for developing pressure ulcers and injuries and had one unstageable DTI that was not present upon admission or reentry. The treatments included a pressure-reducing device for the chair and for the bed, a turning program, a nutrition intervention, and pressure ulcer care. B. Resident interview and observation Resident #4 was interviewed on 8/18/25 at 1:04 p.m. in her room. Resident #4 was sitting in her wheelchair next to her bed in her room. The resident's roommate was also in the room. Resident #4 said she was at the facility because she fell. Resident #4 said she had a pressure wound. Resident #4 said she did not know what the facility was doing to make the pressure wound better. During the interview, Resident #4 did not have any pressure-relieving devices on her right foot. The resident was wearing socks on her feet and a white bandage was sticking out of the top of her right sock. The resident's feet were resting directly on the wheelchair's footrest. There was a large machine next to the resident's bathroom. Resident #4 said she did not know what it was used for. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #4's roommate said the machine was used for Resident #4's foot because she had a wound. C. Observations On 8/19/25 from 11:44 a.m. to 12:48 p.m., Resident #4 was in her wheelchair in the dining room. She had her right foot resting on the ground. She did not have any pressure-relieving devices on her right foot. On 8/19/25 at 6:45 p.m. Resident #4's wound care was observed with the WCP and regional clinical resource (RCR) #2. The wound had slight serosanguinous drainage (a thick light pink color and water consistency often indicating the natural healing was underway). The WCP said the wound was improving and was smaller. The wound measured 2.1 cm in length by 1.7 cm in width and 0.8 cm in depth per the WCP. The WCP said the wound was improving and was smaller. The resident did not have any offloading measures on her right foot prior to the WCP beginning the wound care. On 8/20/25 at 9:15 a.m. Resident #4 was sitting in her wheelchair in her room. The resident was observed without any offloading measures on her right foot. Her feet were resting directly on the footrests of her wheelchair. D. Record review Review of Resident #4's skin integrity care plan, initiated 3/21/25 and revised 8/19/25 (during the survey), revealed the resident had a stage 3 pressure ulcer on her right heel. Interventions included encouraging the resident to shift her weight, initiating an air mattress, and providing vaporous hyperoxia therapy (VHT - a non-invasive treatment for chronic wounds that uses a non-contact, low-frequency ultrasonic mist and concentrated topical oxygen to accelerate healing) as needed for wound healing. -The care plan did not include an intervention for the use of assistive heel protectors and wedges (see WCP visit notes below). Review of Resident #4's April 2025 CPO revealed the following physician's orders: Apply skin prep to the right heel, and allow to dry. Float heel with a pressure relief boot at all times two times a day for the wound to the right heel, ordered 3/22/25 and discontinued 4/24/25. Betadine DTI to the right heel daily. Leave it open to air and offload every night shift. Ordered on 4/4/25 and discontinued on 6/4/25. Review of Resident #4's August 2025 CPO revealed the following physician's orders: Monitor DTI to the right heel. Document no if there are no observed abnormalities to the dressing, skin or pain associated with the wound. Document yes if abnormalities or changes to the dressing, skin, or pain associated with the wound are present or observed. If there are abnormalities, document a descriptive note under the nurse's note and notify the physician, ordered 4/4/25. Air mattress: check air mattress for proper function and settings. Settings based on resident range of 130 to 150 pounds or to the resident's preferred comfort level. Notify maintenance if not functioning properly, ordered 4/24/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Prostat (supplement to promote wound healing). Drink 30 milliliters (ml) twice a day for the promotion of wound healing, ordered 5/2/25. Wound care order: Cleanse the right heel wound with wound cleanser. Apply silver alginate and silicone border dressing. Change three times a week and as needed, ordered 8/20/25. -There were no physician's orders for heel protector boots. A Braden scale (pressure sore assessment risk) assessment, dated 1/19/25, revealed Resident #4 was at risk for pressure ulcers with a score of 19. A Braden scale assessment, dated 3/18/25, revealed Resident #4 was at moderate risk for pressure ulcers with a score of 13. The 4/2/25 weekly wound observation assessment revealed Resident #4 acquired a right heel suspected DTI on 3/21/25. The right heel wound measured 3.5 cm in length, 3.5 cm in width and 0.0 cm in depth. The assessment revealed it was the first observation of the wound. The current treatment plan orders were betadine daily, open to air treatment and offload. The 6/18/25 WCP visit note revealed Resident #4 had a stage 3 pressure injury on her right heel. The right heel wound measured 1.1 cm in length, 1.5 cm in width and 0.4 cm in depth. -Based on the WCP visit note, the right heel wound evolved from a DTI to a stage 3 pressure injury. The 7/9/25 WCP visit note revealed Resident #4 had a stage 3 pressure ulcer on her right heel. The right heel wound measured 1.5 cm in length, 1.5 cm in width and 0.4 cm in depth. The healing was delayed by a local infection. The 7/18/25 nurse note revealed a complete blood count (CBC) lab and wound culture was obtained in the morning for increased wound discharge and foul odor. The resident's vital signs were within normal limits. There were no reports of worsening pain or discomfort. The CBC lab came back with no abnormalities. The July 2025 medication administration record (MAR) revealed amoxicillin-potassium clavulanate 875-125 mg was ordered on 7/19/25. The order read: Take one tablet by mouth every 12 hours for bacterial infection for 10 days. The 7/22/25 weekly wound observation assessment revealed Resident #4's right heel was facility-acquired and was a stage 3 pressure injury. The pressure injury was worsening, there was a foul smell present and there was inflammation present. The wound measured 2.8 cm by 2.0 cm by 0.6 cm. The treatment was to clean with wound cleanser, place gauze soaked with Dakins half strength, border foam, change the dressing daily, and as needed. The resident received VHT with therapy and a new physician's order was given to obtain a culture to rule out osteomyelitis (bone infection). The 7/23/25 nurse note revealed Resident #4 continued on oral antibiotic amoxicillin for a wound infection to the right heel. No adverse reactions were noted. The 7/29/25 weekly wound observation assessment revealed the right heel wound depth was now at the muscle level. The wound culture revealed a light growth of mixed Gram-positive and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Gram-negative flora (the sample identified a small amount of various types of bacteria). The 7/29/25, 8/5/25, 8/12/25 and 8/19/25 weekly wound observation assessments revealed that the preventative measures for Resident #4's pressure wound were an air mattress, assistive heel protectors and wedges. -However, there was no documentation prior to 7/29/25 on what preventative measures were in place to prevent the wound from getting worse. -Additionally, observations revealed Resident #4 was not wearing heel protectors (see observations above). E. Staff interviews The WCP was interviewed on 8/19/25 at 7:45 p.m. The WCP said he was concerned when Resident #4's pressure injury first developed that the pressure injury could go to the bone if the facility did not have interventions in place. He said the resident should wear heel protectors when she was in her wheelchair and she should have an offloading measure for her heels when she was in bed, such as a pillow. He said the wedges in the resident's room should not be used directly on the resident's heel. Registered nurse (RN) #1 was interviewed on 8/20/25 at 10:31 a.m. RN #1 said she knew a resident's daily care needs through the physician's orders. She said the physician's orders were documented on residents' MARs and treatment administration records (TAR). She said there was a communication board in the residents' electronic medical record (EMR) system that detailed specific daily care needs. She said she additionally knew a resident's needs through verbal communication. RN #1 said she knew if a resident needed to wear protective boots because it would be on their TAR. She said if a resident declined wearing protective boots, she documented the refusal in the TAR as N for no. She said she asked a CNA to put the boots on the residents. She said if she did not document an intervention in the TAR, she documented it as a progress note. RN #1 said she was familiar with Resident #4. She said she had a pressure ulcer on her right heel. She said she did not remember how long she had the pressure ulcer but she knew she had had it for a long time. She said there was a time when the pressure ulcer was worse and she said she did not see the wound for over a week. She said she did not know what caused the resident's wound, but she said Resident #4 liked to lie in a certain position and that might have been what caused it. She said she did not work at the facility prior to the resident having the pressure ulcer. She said heel protector boots were an intervention to help promote the pressure ulcer to heal. She said she knew because it was on Resident #4's TAR. -However, RN #1 looked at Resident #4's August 2025 TAR during the interview and she said she did not see an order for the heel protector boots. RN #1 said she tried to use a towel instead of a heel protector boot to offload the resident's heel because Resident #4 did not like to wear the heel protector boot. She said it was important to try something to take pressure off the heel to reduce pressure to make the wound better. RN #1 said Resident #4 used the heel protector boot because she had seen the heel protector boot in the resident's room. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-However, several observations revealed Resident #4 was not wearing a heel protector boot (see observations above). During the interview, RN #1 went to Resident #4's room. RN #1 found heel protective boots in the resident's closet. Resident #4 was in her wheelchair next to her bed in her room. Resident #4 said she refused to wear the boot at times because of the way it was secured to her foot. -However, there was no documentation in the resident's EMR to indicate the resident had heel protector boots that were to be applied or that she refused to wear them (see record review above). The director of nursing (DON) was interviewed on 8/20/25 at 3:08 p.m. The DON said nurses were responsible for ensuring residents wore heel protector boots to offload heel pressure. She said nurses and certified nurse aides (CNA) knew which residents were supposed to wear heel protector boots based on the resident's care plan, their TAR and the EMR communication board. The DON said if a resident refused to wear a heel protector boot, the nurse should ask another nurse to try to educate the resident on why they should wear the heel protector boot. The DON said if the resident refused to wear the heel protector boots after education attempts by two nurses, then the DON tried to educate the resident on the importance of wearing the heel protector boots. She said if the resident refused to wear the heel protector boot after she provided education, she might ask the social services director (SSD) to talk with the resident. She said she would then discuss the resident's refusals with the interdisciplinary team (IDT), including the physician. The DON said she was familiar with Resident #4. She said the resident had a pressure ulcer on her right heel that was facility-acquired. She said she did not know when the pressure ulcer was identified, what caused it or what interventions were in place prior to the pressure ulcer because the DON said she did not start working at the facility until July 2025. She said Resident #4 had had a right heel pressure ulcer at least since June 2025. The DON said the right heel wound was infected and treated successfully with antibiotics in July 2025. -However, the resident developed the pressure ulcer in March 2025 (see record review above). The DON said the intervention in place for Resident #4's pressure ulcer was an air mattress. The DON said there was no physician's order and no care plan for the resident to wear heel protector boots as an intervention. She said since there was no physician's order and no interventions identified in Resident #4's care plan, the staff did not know what interventions to use to promote the healing of the pressure ulcer. -However, the WCP wound visit notes, beginning 7/29/25, identified the resident should have heel protectors as an intervention (see record review above). The DON said if Resident #4 refused the heel protector boot in the past and IDT determined it was not a successful intervention, the resident's care plan should have been updated to reflect that the resident refused to wear the heel protector boot. IV. Resident #52 A. Resident status Resident #52, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	diagnoses included type 2 diabetes mellitus, bipolar disorder, protein-calorie malnutrition, adult failure to thrive and schizoaffective disorder. The 7/16/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was dependent on staff assistance for toileting hygiene, shower/bathing, upper and lower body dressing, personal hygiene and all transfers. He required substantial/maximal assistance for rolling side to side. The assessment revealed no behavioral symptoms or rejection of care. The assessment revealed the resident was at risk of developing pressure ulcers and had one unstageable deep tissue injury that was not present upon admission. The assessment revealed the skin and ulcer/injury treatments included a pressure reducing device for his chair, a pressure reducing device for his bed, was on a turning/repositioning program, had a nutrition or hydration intervention to manage skin problems, received pressure ulcer/injury care and had an application of dressings to his feet (with or without topical medications). B. Resident interview and observations On 8/17/25 at 5:59 p.m. Resident #52 was lying on his side in bed with bilateral pressure relieving boots on. An air mattress was in place on the bed. Resident #52 said he had no concerns or complaints. On 8/19/25 at 6:20 p.m. Resident #52's wound care was observed with the WCP and RCR #2. Resident #52's pressure relieving boots were removed and the old dressing, which was dated 8/18/25, was removed from his left heel. The old dressing had moderate serosanguinous (a yellowish, thin, watery discharge with small amounts of red blood) drainage present on it. Resident #52's left heel wound was 6.2 cm in length by 4.5 cm in length by 0.2 cm in depth, per the WCP. The wound was completely covered in 100% (percent) black eschar (a layer of dead, dried tissue that forms over a wound that is typically black or brown in color). The WCP said the left heel wound was considered slightly worsened due to the length of it having increased slightly but it was stable. The WCP applied the contents of a Flagyl capsule (medication used to help control odor in wounds) to the wound prior to applying a new dressing. The WCP next removed the dressing from Resident #52's coccyx wound. The old dressing had very light pink drainage on it. The wound was 0.5 cm in length by 0.7 in width by 0.0 cm in depth, per the WCP. The WCP said the wound was improving. The wound was 100% granulated tissue (a type of new, pink or red tissue that forms in the wound bed during the healing process). The WCP applied a new dressing to the wound. C. Record review Review of Resident #52's skin impairment/pressure ulcers risk for impaired skin integrity care, initiated 4/15/25, revealed the resident was at risk for skin impairment/pressure ulcers related to limited mobility with an existing DTI to his left heel. Interventions included educating the resident about proper skin care to prevent skin breakdown, educating the resident about the proper usage of pressure reducing devices, educating the resident on the importance of keeping skin clean and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	moisturized, encouraging the resident to frequently shift weight, evaluating the resident's skin and the resident would have pressure relieving boots on when in bed and when up in his wheelchair. -Review of the care plan revealed there had been no new interventions added after Resident #52 developed a left heel DTI on 6/10/25 and developed a stage 3 coccyx pressure ulcer on 8/12/25. Review of Resident #52's potential for pressure ulcer development care plan, initiated on 4/18/25, revealed the resident had the potential for pressure ulcer development related to immobility. Interventions included administering medications as ordered, monitoring/documenting for side effects and effectiveness, administering treatments as ordered and monitoring for effectiveness, educating the resident/family/caregivers as to causes of skin breakdown, including transferring/positioning requirements, the importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, following facility policies/protocols for the prevention/treatment of skin breakdown, if the resident refused treatment, conferring with the resident, the IDT and the family to determine why and try alternative methods to gain compliance, documenting alternative methods, informing the resident/family/caregivers of any new areas of skin breakdown and instructing/assisting the resident to shift his weight in his wheelchair every 15 minutes. -Review of the care plan revealed there had been no new interventions added after Resident #52 developed a left heel DTI on 6/10/25 and developed a stage 3 coccyx pressure ulcer on 8/12/25. Review of Resident #52's August 2025 CPO revealed the following physician's orders: May refer to wound consultant for evaluation and treatment as needed, ordered 4/14/25. Monitor blister to left heel. If there are abnormalities, document a descriptive note under the nurses note and notify the physician, ordered 4/14/25. Pressure relieving boot in bed and chair as resident will allow, ordered 4/14/25. Weekly skin and vital sign checks on Monday nights. Document in weekly skin check assessment, ordered 4/14/25. Prostat 30 ml twice per day (BID) for wound diagnosis, ordered 5/9/25. House supplement (generic mighty shake), two times a day as a supplement, ordered 5/9/25. Obtain air mattress per physician, ordered 6/29/25. -However, the facility failed to implement the air mattress intervention and physician's order until 19 days after Resident #52 developed the left heel DTI (on 6/10/25). Obtain bed extender per physician, ordered 6/29/25. Wound care order (left heel): Clean wound with wound cleanser. Apply silver alginate, cover with abdominal (ABD) pad, wrap with kerlix and apply crushed Flagyl for odor control. Change dressing daily and as needed (PRN), ordered 8/20/25. Wound care order (coccyx): Clean wound with wound cleanser. Apply honey gel, border gauze, and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	change the dressing every other day and as needed (PRN), ordered 8/20/25. -However, a physician's order for wound treatment for Resident #52's stage 3 coccyx wound was not entered into the resident's EMR until eight days after the wound was identified on 8/12/25. The 7/29/25 physician wound tracker form revealed Resident #52 had a left heel DTI. Dimensions were 4 cm in length by 3.9 cm in width by 0.1 cm in depth. Treatment included cleaning the wound with wound cleanser and applying silver alginate and a silicone border dressing. The dressing was to be changed three times per week and PRN. The 8/5/25 physician wound tracker form revealed Resident #52 had a left heel DTI. Dimensions were 4.5 cm in length by 4 cm in width by 0.2 cm in depth. Treatment included cleaning the wound with wound cleanser and applying silver alginate and a silicone border dressing. The dressing was to be changed three times per week and PRN. The weekly wound observation tool, dated 8/5/25 documented Resident #52 had a pressure wound on his left heel that was a DTI and was facility-acquired on 6/10/25. Overall, the wound was improving but had necrotic (dead) tissue present. The wound was documented as 4.5 cm in length by 4 cm in width and 0.2 cm in depth. The 8/12/25 physician wound tracker form revealed Resident #52 had a left heel DTI. Dimensions were 4.7 cm in length by 4.4 cm in width by 0.3 in depth. Treatment included cleaning the wound with wound cleanser and applying silver alginate and a silicone border dressing. The dressing was to be changed three times per week and PRN. Crushed Flagyl was to be applied to the wound daily for odor. Additionally, the form documented the resident had a stage 3 pressure wound to his coccyx. Dimensions were 0.7 cm in length by 0.9 cm in width by 0.1 cm in depth. Treatment included cleaning the wound with wound cleanser, and applying honey gel and a border gauze. The dressing was to be changed every other day and PRN. The weekly wound observation tool, dated 8/12/25, documented Resident #52 had a stage 3 pressure wound to the coccyx that was facility acquired on 8/12/25. This was the overall first observation of the wound and there was necrotic tissue present. The wound was documented as 0.7 cm in length by 0.9 cm in width by 0.1 cm in depth. The 8/5/25 weekly skin check assessment revealed Resident #52 had a current left heel wound and treatment was in progress. The 8/11/25 weekly skin check assessment revealed Resident #52 had a current left heel pressure wound that was dark brown with eschar intact. The surrounding skin of the wound had slight maceration (a condition where the skin becomes soft, white, and soggy due to prolonged exposure to moisture). No drainage was noted with the dressing change and treatment in place. All other skin was warm, dry and intact and there were no new abnormalities observed. -The skin check assessment did not indicate the resident had a wound on his coccyx, however on 8/12/25 (the day after the skin assessment) the WCP discovered a stage 3 pressure ulcer on the resident's coccyx. The 8/18/25 weekly skin check assessment revealed Resident #52 had a left heel skin impairment. The left heel wound was currently receiving daily treatments. No new areas of skin impairment were (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	noted or reported. -However, Resident #52 had a stage 3 coccyx pressure ulcer that was identified on 8/12/25 and was still present during the wound care observation on 8/19/25 (see observations above). D. Staff interviews The DON and the NHA consultant were interviewed together on 8/20/25 at 3:25 p.m. The DON said Resident #52's stage 3 coccyx wound had developed in the facility on 8/12/25. The DON said the facility conducted an IDT meeting for pr

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen. Specifically, the facility failed to:-Ensure uncooked meat was separated from ready-to-eat food; -Ensure food was discarded after the date of expiration; -Ensure food was labeled and dated appropriately; and, -Ensure the kitchen was maintained in a clean manner.Findings include: I. Failed to ensure uncooked meat was separated from ready-to-eat foodA. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, (3/16/24), retrieved on 8/27/25 read in pertinent part, Food shall be protected from cross contamination by separating raw animal food during storage, preparation, holding, and display from raw ready-to-eat food including fruits and vegetables. (Chapter 3-10)B. Observations On 8/18/25 at 7:36 a.m., during an initial walk through of the main kitchen, the main kitchen's walk-in refrigerator had a large metal basin on the second to top shelf on the right side of the refrigerator. The large metal basin contained a container of lettuce, yogurt, raspberries, blueberries, and a gallon-sized plastic ziplock bag that was opened. The food in the bag resembled raw bacon. There were liquids leaking out of the ziplock bag and onto the other food items in the large metal basin. C. Staff interviews and observationsThe dietary manager (DM) was interviewed during a walk through of the main kitchen on 8/19/25 at 11:10 a.m. The DM observed the leaking plastic ziplock bag of bacon in the metal basin with ready-to-eat food items in the main kitchen's walk-in refrigerator. The DM said the gallon-sized plastic ziplock bag of raw bacon should have been separated from the ready-to-eat food in the large metal basin. The DM said he did not know if it was raw turkey bacon or raw pork bacon. The DM removed the ziplock bag of bacon from the metal basin. The nursing home administrator (NHA) was interviewed on 8/20/25 at 4:12 p.m. The NHA said he was not aware there was raw bacon stored in the same container of ready-to-eat food in the main kitchen's walk-in refrigerator. The NHA said raw animal food should not be stored in the same area with ready-to-eat food. II. Failed to ensure food was discarded after the date of expiration A. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, (3/16/24), retrieved on 8/27/25, read in pertinent part, The day or date marked by the food establishment may not exceed a manufacturer's use-by-date if the manufacturer determined the use-by date based on food safety. (Chapter 3-25)The Hormel Health Labs Code Date and Handling Information for Hormel Vital Cuisine Mighty Shakes Nutritional Shake - Chocolate (2024), page 12, retrieved on 8/27/25 from https://www.lyonshealthlabs.com/wp-content/uploads/HHL-Code-Date_Handling-Sheet-04_2024.pdf, read in pertinent part, Shelf life: Unopened and frozen - 15 months; Refrigerated and thawed - 14 days; opened - up to four hours. B. ObservationsOn 8/18/25 at 7:36 a.m., during an initial walk through of the main kitchen, the main kitchen's walk-in refrigerator had two large cardboard boxes that contained individual Vital Cuisine Mighty Shakes (a nutritional supplement). One was labeled Vital Cuisine Mighty Shakes Vanilla Flavor with a pulled date of 8/13/25 written in black marker. On the sides of the second cardboard box, which was labeled with Vital Cuisine Mighty Shakes Chocolate Flavor, there was a pulled date of 8/1/25 written in black marker. The cardboard boxes contained 28 individual chocolate Mighty Shakes.-The facility failed to discard the Mighty Shakes chocolate flavor 14 days after they were refrigerated and thawed on 8/1/25. C. Staff interview and observationsThe DM was interviewed during a walk through of the main kitchen on 8/19/25 at 11:10 a.m. The DM observed the boxes of Mighty Shakes in the main kitchen's walk-in refrigerator. He said Mighty Shakes could be stored in the refrigerator for three to six months. He said he did not know there were different shelf lives depending on how the Mighty Shakes were stored. He said the cardboard boxes with the Mighty Shakes were labeled based on when the box was moved from the freezer to the refrigerator. He said based on the 14-day thaw shelf life, the box of chocolate Mighty Shakes should be discarded because it had been more than 14 days since the Mighty Shakes had been put in the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	refrigerator and thawed. The NHA was interviewed on 8/20/25 at 4:12 p.m. The NHA said he did not know the shelf life for Mighty Shakes. He said based on what he was provided from the manufacturer's website for shelf life instructions, the chocolate Mighty Shakes that were labeled with a pulled date of 8/1/25 should have been discarded since it was more than 14 days since the Mighty Shakes had been put into the refrigerator and thawed.III. Failed to ensure food was labeled and dated appropriatelyA. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, (3/16/24), retrieved on 8/27/25 read in pertinent part, A date marking system that meets the criteria may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded or using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the department upon request. (Chapter 3-29) B. Observations On 8/18/25 at 7:36 a.m., during an initial walk through of the main kitchen, on the second to top shelf on the left side of the main kitchen's walk-in refrigerator, there was a square plastic container with a white thick substance in it that looked like frosting. The container was not labeled with a date or the name of the food item inside the container. On the right side of the refrigerator, on the third to top shelf, there were four containers. There was a square plastic container with a red thin sauce that looked like tomato sauce. There was a second square plastic container with a broth, noodles and peas that looked like chicken vegetable noodle soup. There was a third square plastic container with a brown thick sauce that looked like gravy. There was a fourth square plastic container with broth and noodles that looked like chicken noodle soup. None of the four containers were labeled with a date or the name of the food item inside the container.On the right side of the refrigerator there was a large metal basin on the second to top shelf. There was a gallon plastic ziplock bag inside the metal basin that was unopened. It appeared to be what looked like raw bacon. The plastic bag was not labeled with what was inside, when it was opened and when it was supposed to be discarded. C. Staff interviewsThe DM was interviewed during a walk through of the main kitchen on 8/19/25 at 11:10 a.m. The DM observed the containers and the ziplock bag that were not labeled in the main kitchen's walk-in refrigerator. He said all food items removed from the original packaging should be labeled with the name of the food, when it was opened and a use-by date. He said the food in the plastic containers should have been labeled with a use-by date and a common name of the food.The DM said he did not know if the food inside the ziplock plastic bag was raw turkey bacon or raw pork bacon. He said the ziplock bag should have been labeled with what the food was, when it was opened and when it should have been discarded. The DM removed the ziplock bag of bacon from the metal basin. The NHA was interviewed on 8/20/25 at 4:12 p.m. The NHA said all food items removed from the original packaging should be labeled with the name of the food, when it was opened and a use-by date. He said the food in the plastic containers observed on 8/18/25 should have been labeled with a use-by date and a common name of the food. IV. Failed to ensure the kitchen was maintained in a clean manner A. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, (3/16/24), retrieved on 8/27/25 read in pertinent part, Walls and wall coverings shall be designed, constructed, and installed so they are smooth and easily cleanable. (Chapter 6-201) B. ObservationsOn 8/18/25 at 7:36 a.m., during an initial walk-through of the main kitchen, the dish room was observed. The wall of the dishwashing sink, behind the faucet and spray nozzle, had multiple black discolorations that covered an area of approximately twelve inches wide and eight inches long. The wall of the three-compartment sink additionally had multiple black discolorations above the right drainboard of the sink. The black discoloration covered an area of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	approximately 18 inches wide and 24 inches long. The rest of the wall above the three-compartment sink had brown discolorations on it. C. Staff interviews and observationsThe DM was interviewed during a walk through of the kitchen on 8/19/25 at 11:10 a.m. The DM said during the walk through he would talk to the maintenance director (MTD) about the black discolorations in the dish room. He said previous maintenance directors used white caulking and paint to fix the discoloration. The DM said he had not filled out a form to let maintenance know when he needed maintenance's help in the last six months. The DM said he did not notice the black discoloration or brown discoloration on the walls of the dish room. The DM said the kitchen staff deep cleaned the kitchen and dish room weekly, monthly and as needed. He said based on the observations made today, 8/19/25, the deep cleaning needed to include the walls behind the sinks in the dish room and the three-compartment sink. At 11:32 a.m., during the main kitchen walk through, three large sheet trays were in a dishwashing rack on the right drainboard of the three-compartment sink. The sheet trays were leaning against the wall and water was visible on the top sheet tray. The DM said the sheet trays could have caused the black discoloration on the walls in the dish room. The DM removed the sheet trays from where they were leaning against the wall. The MTD and the NHA were interviewed together on 8/20/25 at 11:30 a.m. The MTD said he was not aware of any work orders for the kitchen. The NHA and the MTD said maintenance work orders were requested by a communication application and in a morning meeting. During the interview, an environmental tour was conducted throughout the kitchen and dish room. The MTD said he was not aware of the black discoloration on the wall in the dish room and on the wall above the three-compartment sink in the kitchen. The MTD and the NHA said they would find a longer lasting solution other than caulking and painting the walls to keep the kitchen clean.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide assistance with activities of daily living (ADL) to ensure the highest practicable quality of life and care for four (#23, #65, #8 and #43) out of eight residents reviewed for ADLs out of 45 sample residents. Specifically, the facility failed to provide bathing for Resident #23, Resident #65, Resident #8, and Resident #43 to maintain the residents' personal hygiene. Findings include:I. Facility policy and procedureThe Activities of Daily Living (ADL) policy and procedure, dated 4/11/25, was provided by the nursing home administrator (NHA) on 8/19/25 at 7:37 p.m. It read in pertinent part, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: bathing, dressing, grooming and oral care; eating to include meals and snacks. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility will identify resident triggers through the care area assessment (CAA) process to assess causal factors for decline, potential decline or lack of improvement. The facility will maintain individual objectives of the care plan and periodic review and evaluation.II. Resident #23A. Resident statusResident #23, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included Parkinson's disease (a degenerative disorder that affects the neurons in the brain), diabetes, intracranial injury (head injury) and malnutrition.The 7/22/25 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. She required set up assistance with eating and showering, and substantial assistance with personal hygiene and dressing.B. Resident interviewResident #23 was interviewed on 8/18/25 at 9:36 am. Resident #23 said she had not received her showers as scheduled for several weeks because the facility did not have enough staff to complete the showers.C. Record reviewThe activities of daily living (ADL) care plan, revised 4/21/25, revealed Resident #23 had a self-care performance deficit related to her Parkinson's disease process. Interventions included providing a sponge bath when a full bath or shower could not be tolerated, avoiding scrubbing when bathing/showering, patting dry sensitive skin, checking nail length, trimming and cleaning on bath day and as necessary.Resident #23's shower records for the previous eight weeks were provided by the NHA consultant on 8/20/25 at 12:00 p.m. The shower record documented Resident #23 received 10 showers out of 24 scheduled opportunities between 6/25/25 and 8/20/25.D. Staff interviewsCertified nurse aide (CNA) #6 was interviewed on 8/20/25 at 9:40 a.m. CNA #6 said Resident #23 was scheduled for her showers three times per week. CNA #6 said there were times residents had to wait until the next day to shower as there was not enough time for staff to complete the showers. CNA #6 said sometimes showers did not get documented, especially on night shift.CNA #4 was interviewed on 8/20/25 at 9:55 a.m. CNA #4 said Resident #23 did not typically refuse her showers. CNA #4 said that most residents were not getting all of their showers as the facility did not typically have enough CNAs to get the showers completed. The director of nursing (DON) was interviewed on 8/20/25 at 3:05 p.m. The DON said Resident #23 should have received her showers as scheduled, however, she did not. The DON said it was important for residents to have showers as scheduled for both hygiene and the residents' well-being.III. Resident #65A. Resident statusResident #65, age [AGE], was admitted on [DATE]. According to the August 2025 CPO, diagnoses included dementia, chronic obstructive pulmonary disease (COPD - a lung disease), anxiety and kidney disease. The 6/29/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. He required set up assistance with eating and moderate assistance with showering, personal hygiene and dressing.B. Resident interview and (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observationResident #65 was interviewed on 8/17/25 at 3:07 p.m. Resident #65's hair was disheveled. Resident #65 said he was supposed to shower every few days, but it had been about a week since he had showered. Resident #65 said on 8/17/25, he washed himself up as well as he was able to by using the sink in his room.C. Record reviewThe ADL care plan, revised 3/10/25, revealed Resident #65 had a self-care deficit related to dementia. Interventions included providing one person assistance with bathing, allowing sufficient time for dressing and undressing and encouraging the resident to participate to the fullest extent possible.Resident #65's shower records for the previous eight weeks were provided by the NHA consultant on 8/20/25 at 12:00 p.m. The shower record documented Resident #65 received 11 showers out of 24 scheduled opportunities between 6/25/25 and 8/20/25.D. Staff interviewsCNA #6 was interviewed on 8/20/25 at 9:40 a.m. CNA #6 said Resident #65 was scheduled for his showers three times per week. CNA #4 was interviewed on 8/20/25 at 9:55 a.m. CNA #4 said Resident #65 typically did not refuse her showers. CNA #4 said Resident #65 often appeared to have greasy, dirty hair when she arrived at work and it was clear to her that he had not received all of his showers.The DON was interviewed on 8/20/25 at 3:05 p.m. The DON said Resident #65 should have received his showers as scheduled, however, it was clear he had missed showers over the past two months. IV. Resident #8A. Resident statusResident #8, age [AGE], was admitted on [DATE]. According to the August 2025 CPO, diagnoses included schizophrenia (mental illness), severe obesity, emphysema (lung disease) and Parkinson's disease. The 6/19/25 MDS assessment revealed the resident had a moderate cognitive impairment with a BIMS score of nine out of 15. He required supervision with eating and bathing and moderate assistance with personal hygiene and dressing.B. Resident representative interviewResident #8's representative was interviewed on 8/18/25 at 11:29 a.m. The representative said she visited Resident #8 last month and he was not groomed. The representative said his hair was long, disheveled and greasy. The representative said Resident #8 had body odor and the room smelled.C. Record reviewThe ADL care plan, revised 6/3/25, revealed Resident #8 had a self-care deficit. Interventions included extensive assistance of one staff for bathing/showering and to encourage Resident #8 to participate to the fullest extent possible.Resident #8's shower records for the previous eight weeks were provided by the NHA consultant on 8/20/25 at 12:00 p.m. The shower record documented Resident #8 received 11 showers out of 16 scheduled opportunities between 6/25/25 and 8/20/25.D. Staff interviewsCNA #6 was interviewed on 8/20/25 at 9:40 a.m. CNA #6 said Resident #8 was scheduled for his showers two times per week. CNA #4 was interviewed on 8/20/25 at 9:55 a.m. CNA #4 said Resident #8 typically did not refuse his showers. CNA #4 said Resident #8 often appeared to have greasy, dirty hair when she arrived at work and it was clear to her that he had not received all of his showers.The DON was interviewed on 8/20/25 at 3:05 p.m. The DON said Resident #8 should have received his showers as scheduled, however, it was clear he had missed showers over the past two months. V. Resident #43A. Resident statusResident #43, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included spondylosis with radiculopathy (compression in the spinal column causing pain, tingling, numbness in arms and legs), muscle wasting and bipolar disorder (a disorder associated with episodes of mood swings from depressive lows to manic highs).The 8/25/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with eating and required moderate assistance with showering, personal hygiene and dressing.B. Resident observation and interviewResident #43 was interviewed on 8/18/25 at 11:35 a.m. Resident #43 appeared to be unshaven with at least one half inch of hair growth on his face. Resident #43 said he was not getting all of his showers. He said he was supposed to have showers on Fridays and Mondays, and he often did not get the Friday shower until Saturday and sometimes did not get the Monday shower at all. Resident #43 said he would like to have his facial hair shaved at least once a week, and it had been several weeks since the facial hair was shaved.C. Record reviewThe ADL care plan, revised 7/21/25, revealed Resident #43 had a self-care performance deficit related to limited mobility. Interventions included providing assistance of one staff for bathing and (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showering and transferring, and dependence on staff for personal hygiene and oral care. Resident #43's shower records for the previous five weeks since admission were provided by the NHA consultant on 8/20/25 at 12:00 p.m. The shower record documented Resident #43 received seven showers out of 10 scheduled opportunities between 7/12/25 and 8/20/25.D. Staff interviewsCNA #6 was interviewed on 8/20/25 at 9:40 a.m. CNA #6 said Resident #43 was scheduled for his showers two times per week. CNA #4 was interviewed on 8/20/25 at 9:55 a.m. CNA #4 said Resident #43 typically did not refuse any showers and it was likely staff had missed some showers.The DON was interviewed on 8/20/25 at 3:05 p.m. The DON said Resident #43 should have received his showers as scheduled, however, it was clear he had missed showers since his admission. The DON said she and the regional clinical resource (RCR) were evaluating residents' missed showers and were working on a plan to ensure residents were provided showers as scheduled.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review and interviews, the facility failed to ensure proper storage of medications for one of three medication storage rooms and three of three medication storage carts.Specifically, the facility failed to:-Date residents' insulin pens with the date it was opened;-Label residents' insulin pens with the resident's name; -Discard medication that had expired; and,-Discard open medications from a medication refrigerator for a resident who had been discharged several months earlier. Findings include:I. Professional referenceAccording to the manufacturer Sanofi-Aventis, How to Inject Lantus with a Vial and Syringe, December, 2024, retrieved on 8/26/25 from https://www.lantus.com/how-to-use/how-to-inject, The Lantus vials you are using should be thrown away after 28 days, even if it still has insulin left in it.II. Facility policy and procedureThe Medication Storage policy, revised April 2025, was provided by the nursing home administrator on 8/19/25 at 1:02 p.m. It read in pertinent part, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security. The medication carts and all medication rooms are routinely inspected by the consultant pharmacist or designee for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs policy.III. Observations and interviewsOn 8/18/25 at 3:03 p.m. the East medication cart was observed with registered nurse (RN) #2. The following medications were found:-A used HumaLog insulin pen, which was not labeled with the resident's name. The pen was inside a storage bag which also contained a glucometer for Resident #49.-A used insulin glargine pen and Lispro insulin pen, which were not labeled with the resident's name. The pens were inside a storage bag ,which also contained a glucometer for Resident #34.-A used insulin glargine pen which was not labeled with the resident's name. The pen was stored inside a storage bag which also contained a glucometer for Resident #11.RN #2 said the insulin pens should have been labeled with the residents' names.On 8/18/25 at 3:20 p.m., the medication refrigerator in the East overflow medication storage room was observed with RN #2. A lorazepam (antianxiety medication) two milligram (mg) per milliliter (ml), 30 ml container was found labeled with the name of a resident, who had expired on 6/19/25.RN #2 said the medication should have been removed from the refrigerator within 48 hours of the resident's death.On 8/18/25 at 3:30 p.m., the [NAME] medication cart was observed with RN #3. The following medications were found:-A used Symbicort (inhaler used to treat asthma) 160/4.5 micrograms (mcg) inhaler for Resident #17 was not labeled with the date it was opened. RN #3 said the inhaler should be labeled with the date it was opened.-A used Trelegy Ellipta (inhaler used to treat asthma, bronchitis and emphysema) 100 mcg/62.5 mcg/25 mcg inhaler for Resident #8 was not labeled with the date it was opened. RN #3 said she did not know how long the inhaler could be used once it was opened. RN #3 said the inhaler should have had a date opened label.-A used fluticasone propionate and salmeterol (inhaler used to treat asthma and lung disease)100 mcg/50 mcg inhaler for Resident #5 was not labeled with the date it was opened. RN #3 said she did not know how long the inhaler could be used once it was opened and said it should be labeled with the date it was opened. -A used Lantus Solostar insulin pen, which was not labeled with the resident's name and not labeled with the date it was opened. The pen was inside a storage bag, which also contained a glucometer for Resident #12. RN #3 said the pen should be labeled with the resident's name and the date it was opened. RN #3 said she would notify her supervisor, as she did not know if the pen should be discarded.-A used NovoLog insulin pen and Lantus Solostar insulin pen for Resident #20, which were not labeled with the date they were opened. RN #3 said they should have been labeled with the date opened. -A used NovoLog insulin pen, which (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was not labeled with the resident's name. The pen was inside a storage bag, which contained Resident #7's glucometer. The NovoLog pen was not labeled with the date it was opened. There was also an opened Lantus insulin pen for Resident #7 that was not labeled with the date it was opened.-A used Lantus insulin pen and HumaLog insulin pen were not labeled with the resident's name. The pens were inside a storage bag which contained Resident #69's glucometer. Both insulin pens were not labeled with the date they were opened.-A used Lantus insulin vial which was not labeled with the resident's name. The vial was in a storage bag which contained Resident #3's name. The Lantus insulin vial had a date opened label of 7/1/25. RN #3 said the medication should have been discarded as it was expired.-An unopened Naloxone Hcl (used to treat opioid overdose) 4 mg package labeled with Resident #3's name, with an expiration date of July 2025. RN #3 said the medication should have been discarded by 8/1/25. On 8/18/25 at 3:50 p.m., the Central medication cart was observed with RN #1 The following medications were found:-A used Lantus Solostar insulin pen for Resident #6, which was not labeled with the date it was opened. RN #1 said the insulin should have been labeled with the date opened. RN #1 said if insulin was used beyond the recommended length of storage, it might not be as effective.-A used Lantus vial for Resident #41, which was labeled with date opened 5/27/25. RN #1 said the insulin was expired and should have been discarded. RN #1 said she was not sure what the facility policy said about the storage of insulin, but her general rule was that the insulin should not be stored longer than 28 days.-A used NovoLog 100 unit vial for Resident #66, which was not labeled with a date it was opened (on the vial or on the box). IV. Staff interviewsThe director of nursing (DON) and regional clinical resource (RCR) #1 were interviewed together on 8/18/25 at 4:30 p.m. The DON said the insulins that dated 5/27/25 and 7/1/25 were both expired and should have been discarded. The DON said all insulins and inhalers should be labeled with the date opened and the resident's name. The DON said medications should be discarded when residents were discharged from the facility. The DON said all medications should be discarded upon expiration.RCR #1 said she was going to review every insulin and inhaler medications on the medication carts to ensure there were no unlabeled, expired or discontinued medications.RCR #1 was interviewed again on 8/18/25 at approximately 5:30 p.m. She said all opened insulin and inhaler medications that were not labeled with resident names and/or the date they were opened had been discarded, medications were removed from the facility for residents who were discharged and expired medications were discarded. RCR #1 said the facility would be providing education to nursing staff regarding medication storage.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to establish an effective antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for two (#3 and #7) of five residents reviewed for antibiotic use out of 45 sample residents. Specifically, the facility failed to: -Develop and implement an effective facility-wide system to monitor the use of antibiotics; and, -Effectively track and monitor the use of antibiotics for Resident #3 and Resident #7.Findings include:I. Professional reference According to The Centers for Disease Control and Prevention's (CDC) Core Elements of Antibiotic Stewardship for Nursing Homes, (2024), retrieved on 8/26/25 fromhttps://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html, To track how and why antibiotics are prescribed, providers perform reviews on resident medical records for new antibiotics started to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians.II. Facility policy and procedureThe Infection Surveillance policy and procedure, dated 4/25/25, was provided by the nursing home administrator (NHA) on 8/17/25 at 4:33 p.m. It read in pertinent part, The nurses participated in surveillance through assessment of residents and reporting changesin condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections. Examples of notification triggers include, but are not limited to a resident developing signs and symptoms of infection, a resident being started on an antibiotic, a microbiology test being ordered, a resident being placed on isolation precautions, whether empirically or by physician order and a microbiology test result showing drug resistance. The facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread by identifying: data to be collected, including how often and the type of data to be documented, including the infection site, pathogen (if available), the signs and symptoms, and resident location, including summary and analysis of the number of residents (and staff, if applicable) who developed infections. III. Failed to develop and implement an effective facility-wide system to monitor the use of antibioticsA. Record review The June 2025 through August 2025 infection preventionist's (IP) infection surveillance binder was reviewed and revealed the following: The facility IP's infection surveillance binder was labeled 2025 and had 12 dividers labeled for each month of the year. For June 2025, July 2025 and August 2025, there was a map of the facility. On the bottom of the page in the middle, the following was handwritten: skin, respiratory, urinary, GI (gastrointestinal tract) and other. The June 2025 antibiotic surveillance log revealed the following column headers: date, resident's name, room number, antibiotic order, diagnosis, ordering practitioner, documentation supporting necessity and ordered upon admission. -There were 13 residents identified on the surveillance log. Of the 13 residents identified, one resident did not have the ordering practitioner's name column or the documentation supporting the necessity column filled out. The July 2025 antibiotic surveillance log revealed the following column headers: resident's name, age, room number, unit, date of admission, date of infection, site of infection, symptoms present on admission, pathogen, community or health care associated and comments. -There were 11 residents identified on the surveillance log. Two of the 11 residents did not have the site of infection column filled out. Eight of the 11 residents did not have the pathogen column filled out. Two of the 11 residents did not have the community or health care-associated column filled out. The August 2025 antibiotic surveillance log revealed the following column headers: date, resident's name, room number, antibiotic order, diagnosis, ordering practitioner, documentation supporting necessity and ordered upon admission. There were 10 residents identified on the surveillance log. Nine of the 10 residents did not have the documentation supports the necessity column filled out. B. Staff interviews The IP was interviewed (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 8/19/25 at 5:45 p.m. The IP said she was responsible for the facility's infection control and prevention program. She said she had worked as the IP for the past month. She said the process for monitoring and tracking resident infections included checking the physician's orders for the antibiotics. She said the physician's order should have an end date for the antibiotic and a diagnosis that the antibiotic was prescribed for. She said the diagnosis should be appropriate for the antibiotic use. She said there should be a culture and sensitivity completed to check for allergies and appropriateness. She said if a resident had symptoms of an infection, such as a urinary tract infection (UTI), she completed an assessment that included monitoring the resident's vital signs, contacting the physician and determining if cultures and labs were needed. The IP said she monitored residents for adverse reactions from the initial dose of an antibiotic until at least a couple of days after the last day of antibiotic use. She said not every nurse in the facility did it the same way, and there should be an alert in the resident's chart for the nurse to know to monitor for adverse reactions related to antibiotics. The IP said she had not used the antibiotic surveillance log since she started working at the facility. The director of nursing (DON) and regional clinical resource (RCR) #1 were interviewed together on 8/20/25 at 1:10 p.m. The DON said she had just completed her course in IP certification in July 2025. RCR #1 said she was working with the DON and the IP to have a consistent way to track infections and antibiotic use in the facility. RCR #1 said the IP was responsible for the facility's infection control and prevention program. RCR #1 said the IP had been in the IP position since August 2025. The DON said she used an audit tool from the electronic medical record (EMR) system that identified what antibiotics were ordered for residents in the past 24 hours. The DON said she used that to check to see if the nurses used McGeer's criteria (standardized tool used to identify potential infections and guide antibiotic stewardship efforts) or a change of condition evaluation form for the assessment. The DON said the nurse who contacted the physician for an antibiotic order was responsible for completing the assessment. RCR #1 said the IP or the DON checked to make sure an assessment was done by the nurse. RCR #1 said since she started in her role, she had identified that assessments were not completed for all residents who were placed on an antibiotic at the facility. RCR #1 said the IP was responsible for using the antibiotic surveillance log. The antibiotic surveillance logs for June 2025 through August 2025 were reviewed with the DON and RCR #1. The DON and RCR #1 said the surveillance logs were not used to track infections and antibiotic use correctly in the facility. RCR #1 said the facility needed to update the logs to reflect how they tracked infections and antibiotic use. The DON and RCR #1 said the map of the facility had not been used to map infections since they both had started working at the facility. IV. Failed to monitor the use of antibiotics for Resident #3 and Resident #7A. Resident #31. Resident statusResident #3, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included chronic kidney disease with heart failure, chronic respiratory failure, type 2 diabetes mellitus, idiopathic aseptic necrosis of the right hand (condition where the bone tissue in the right hand dies due to a lack of blood supply with no identifiable cause), dependence of renal dialysis, systemic lupus erythematosus, acquired absence of the right leg below the knee, depression and anxiety. According to the 7/15/25 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She had an impairment in one upper extremity and used a wheelchair. She required set up assistance with eating, and she was dependent on staff assistance for toileting and showering. She required substantial assistance with oral hygiene and personal hygiene. The assessment revealed the resident was not on an antibiotic. -However, review of Resident #3's EMR revealed the resident received an antibiotic from 8/14/25 to 8/18/25 (see record review below). 2. Resident interview Resident #3 was interviewed on 8/19/25 at 9:26 a.m. Resident #3 said she had a bandage on her left hand because her fingers and finger tips were contracted and physical therapy taught her an exercise to prevent them from worsening. Resident #3 showed her right hand as she explained what happened and said the yellow circles on the palm of her right hand and the fingernails were bent from her kidney failure. She said her left hand (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	looked the same until she did the exercises. She said she had a cut, and it was infected and was treated with antibiotics. She said she did not know what caused the infection. She said sometimes the bandages were not secure. 3. Record review Review of the skin integrity care plan, initiated 11/26/24 and revised 8/20/25 (during the survey), revealed Resident #3 had altered skin integrity related to limited mobility. She had multiple discolored white areas on her body related to long-term use of triamcinolone (a steroid medication to treat autoimmune and inflammatory diseases). She had an actual skin issue to her left middle finger as of 8/15/25 and discontinued oral antibiotics on 8/19/25. Interventions included following treatment orders as needed, notifying the physician if skin impairment did not respond to the current treatment regimen or the resident experienced an adverse reaction. Review of Resident #3's August 2025 CPO revealed the following physician's order: Amoxicillin-potassium clavulanate (antibiotic) 250-125 milligrams (mg). Take one tablet by mouth two times a day for right-hand wound infection for five days, ordered 8/13/25. -Review of the IP infection surveillance documents from 8/1/25 to 8/19/25 revealed the facility did not identify Resident #3's right-hand wound infection on the infection tracking log. -Review of Resident #3's EMR revealed that the facility was not consistently monitoring for adverse reactions related to the use of an antibiotic. B. Resident #71. Resident statusResident #7, age [AGE], was admitted on [DATE] and readmitted on [DATE], after a four-day hospitalization for acute cholecystitis (inflammation of the gallbladder). According to the August 2025 CPO, diagnoses included type 2 diabetes mellitus, chronic kidney disease, acquired absence of the right leg below the knee, benign prostatic hyperplasia with lower urinary tract symptoms, chronic gastritis and melena.According to the 7/9/25 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. He had impairment on one lower extremity. He required a wheelchair. He required set up assistance with eating and oral hygiene. He required maximal assistance with toileting and personal hygiene. He was dependent with showeringThe assessment revealed he was taking an antibiotic and an indication for the antibiotic was noted.2. Record reviewReview of Resident #7's catheter care plan, initiated 12/16/2020 and revised 4/24/25, revealed the resident had a suprapubic catheter related to obstructive and reflex uropathy (a condition where urine flows backward from the bladder up into the ureters and the kidneys). Interventions included checking catheter tubing for kinks when it appeared not to be draining properly, enhanced barrier precautions, observing and documenting for pain and discomfort due to the catheter, observing, recording, and reporting to the doctor for signs and symptoms of UTI.Review of Resident #7's June 2025 CPO revealed the following physician's order: Vancomycin hydrochloride (HCl) (antibiotic) 125 mg. Take one capsule by mouth two times a day for cholecystitis for 21 days, ordered 6/14/25. -Review of the IP infection surveillance documents from 6/1/25 to 8/19/25 revealed the facility did not identify Resident #7's antibiotic use for his cholecystitis on their infection tracking log. -Review of Resident #7's EMR revealed that the facility was not consistently monitoring for adverse reactions related to the use of an antibiotic. -Review of Resident #7's EMR revealed the facility did not care plan the resident's use for an antibiotic from June 2025 to July 2025. C. Staff interviews The IP was interviewed on 8/19/25 at 5:45 p.m. The IP said the facility's process for monitoring and tracking infections and antibiotic use included making sure the McGeer's criteria were met when a new antibiotic was started or a resident was admitted to the facility on an antibiotic. The IP said she discussed antibiotic usage with the medical director when an antibiotic was first ordered, when labs were needed and as needed. The IP said the medical director reviewed antibiotic use as needed if the resident was not improving, to monitor for efficacy and if sensitivity was obtained. The IP said if a resident was started on an antibiotic or if a resident had an infection, it was considered a change in condition and there should be a change in condition assessment completed. The IP said residents should be monitored for adverse reactions and there should be a care plan in place for antibiotic use. The IP said she was familiar with Resident #3 and Resident #7. She said she was not working at the facility when Resident #7 was placed on an antibiotic and she did not know if he was monitored for adverse reactions or if there was a care plan related to the use (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the antibiotic. The DON and regional clinical resource (RCR) #1 were interviewed on 8/20/25 at 1:10 p.m. The DON said residents should be monitored for adverse reactions related to antibiotic use once a resident started on an antibiotic until the resident stopped taking the antibiotic. RCR #1 said the facility was not consistent on how to monitor for residents' adverse reactions, and she planned to educate nurses on what to know to monitor for adverse reactions by using an alert charting function in the facility's EMR system. The DON and RCR #1 said the antibiotic use and the type of infection should be documented in the resident's care plan. The DON and RCR #1 said they were familiar with Resident #3 and Resident #7. The DON said Resident #3 and Resident #7 did not have consistent monitoring for adverse reactions related to their antibiotic use. RCR #1 said she reviewed the care plans for Resident #3 and Resident #7 and said they demonstrated the antibiotic use and that the infection was identified. -However, after review of the care plan documents, there was no care plan for Resident #3 and Resident #7's antibiotic use.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report alleged violations of potential abuse to the state oversight agency in accordance with state laws for one of three allegations. Specifically, the facility failed to timely report an allegation of resident-to-resident verbal abuse of Resident #5 by Resident #32 to the State Agency.Findings include: I. Facility policy and procedure The Abuse, Neglect and Exploitation policy and procedure, dated 4/11/25, was provided by the nursing home administrator (NHA) on 8/17/25 at 4:33 p.m. It read in pertinent part, Abuse is defined as the willful infliction of injury with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.Alleged violation is a situation or occurrence that is observed or reported by staff, residents, relatives, visitors, or others but has not yet been investigated and, if verified, could be an indication of noncompliance with the federal requirements related to abuse. Possible indicators of abuse include but are not limited to verbal abuse of a resident overheard.The facility will develop and implement written policies and procedures that establish policies and procedures to investigate any such allegations.An immediate investigation is warranted when suspicion, or reports, of abuse occur. Reporting of all alleged violations to the administrator, State Agency, adult protective services and to all other required agencies within the specified timeframes. If the event that caused the allegation involves abuse or resulted in serious bodily injury or no later, report within two hours. If the event that caused the allegation does not involve abuse or result in serious bodily injury, report within 24 hours.II. Allegation of verbal abuse of Resident #5 by Resident #32 A. Resident #5 - alleged victim 1. Resident status Resident #5, age greater than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included dementia, chronic obstructive pulmonary disease and chronic kidney disease. According to the 7/2/25 minimum data set (MDS) assessment, the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. She required a wheelchair and set up assistance with eating. She required supervision with eating and moderate assistance with toileting and personal hygiene. She required maximal assistance with showering. The assessment revealed she did not exhibit any physical or verbal behaviors during the look-back period. C. Resident #32 - alleged assailant1. Resident status Resident #32, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included dementia, spondylosis (age-related wear and tear of the spinal disks), depression, obsessive-compulsive disorder and anxiety disorder. According to the 8/11/25 MDS assessment, the resident was cognitively impaired with a BIMS score of 11 out of 15. She required a walker and was independent with eating and toileting. She required set-up assistance with oral and personal hygiene and supervision with showering, The assessment revealed she did not exhibit any physical or verbal behaviors during the look-back period. 2. Resident record review The 7/27/25 nurse progress note revealed the nurse was notified by a certified nurse aide (CNA) the resident was verbally aggressive towards her roommate, Resident #5. The CNA reported they heard Resident #32 yelled at her roommate, and so the CNA asked the resident to be kind to her. Resident #32 yelled to Resident #5, Well, my husband is going to come in here and kill you. Resident #32 was asked if she wanted to go to the dining room for coffee. Resident #32 was educated on being polite to others and that threats could not be made. Resident #32 was in the dining room, drinking coffee with purposeful rounds. -On 8/19/25 at 10:41 a.m., the facility was unable to provide documentation that the incident of alleged verbal abuse was reported to the State Agency. III. Staff interviews The NHA and regional clinical resource (RCR) #1 were interviewed together on 8/19/25 at 10:41 a.m. The NHA said he was not familiar with the 7/27/25 nurse progress note for Resident #32. He said he would look into it. RCR #1 said there might be a soft file on the incident. The NHA was interviewed a second time on 8/19/25 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 2:22 p.m. The NHA said he reported the alleged event (during the survey) because, based on what was documented in Resident #32's medical record, it was a reportable event. The NHA said the nurse who wrote the progress note in Resident #32's medical record was not working and he was trying to reach her to gather additional information, including the name of the CNA who witnessed the event. He said while he was investigating the alleged abuse, Resident #32 would be placed on one-on-one staff supervision. He said all staff received education (during the survey) on what abuse was and to contact him, the abuse coordinator, if there was suspected abuse. He said a facility-wide interview had been initiated with all residents to ensure all residents felt safe and were not fearful.The NHA said he was the abuse coordinator. He said the staff had two hours to report possible abuse to him as the abuse coordinator. He said the first thing the staff should do when reporting abuse was to make sure the residents were safe. He said the facility then started the investigation that included interviewing the alleged assailant and victim to determine if there was abuse. The NHA was interviewed a third time on 8/20/25 at 4:34 p.m. The NHA said he did not talk to the nurse who documented the 7/27/25 progress note in Resident #32's medical record. He said the nurse used to work more often but now she worked as needed. The NHA said the nurse would not be allowed to work until she was interviewed about the alleged abuse incident involving Resident #32 and Resident #5. The NHA said he was not able to identify the CNA mentioned in the progress report who reported the alleged abuse to the nurse. He said the facility did an audit of progress notes (during the survey) to see if there were any other residents who could have been affected. The NHA said the other staff who worked on 7/27/25 would be interviewed to ensure a complete and thorough investigation was conducted. He said as of 8/20/25, the investigation into the abuse allegation involving Resident #32 and Resident #5 was ongoing and he had not been able to substantiate or unsubstantiate the alleged abuse. CNA #3 was interviewed on 8/20/25 at 5:49 p.m. CNA #3 said she reported abuse to the NHA because he was the abuse coordinator. She said if she heard a resident have a verbal altercation with another resident, she would try to intervene to keep the residents safe and then she would report the incident to the NHA.

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	065174	A. Building B. Wing	08/20/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#39) of three residents received care and services according to acceptable standards of clinical practice out of 45 sample residents. Specifically, the facility failed to ensure Resident #39 did not receive Excedrin (migraine relief medication) without a physician's order. Findings include:I. Facility policy and procedureThe Medication administration policy, revised 4/16/25, was provided by the nursing home administrator (NHA) on 8/19/25 at 1:02 p.m. It read in pertinent part, Medications are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. Nursing staff are required to ensure the six rights of medication administration, which include:-The right resident;-The right drug;-The right dosage;-The right route;-The right time; and-The right documentation. Nursing staff must review the medication administration record (MAR), compare the medication source with the MAR to verify accuracy, administer medications within 60 minutes before or after the scheduled time unless otherwise ordered, sign the MAR after administration, and report or document adverse side effects or refusals.II. Resident #39Resident #39, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included insufficient sleep syndrome (sleep disorder where a person does not get enough sleep), heart failure and major depressive disorder recurrent severe without psychotic features.A. Resident statusThe 7/26/25 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required set-up or clean-up assistance with bathing and eating. The assessment documented Resident #39 experienced pain that affected her sleep, therapy participation and day to day activities.B. Resident interviewResident #39 was interviewed on 8/18/25 at 12:41 p.m. Resident #39 said she suffered from migraines and tried to get medication when the pain became severe. She said she was on other migraine medications as a preventative measure, but Excedrin Migraine was the only medication that helped when she had an active migraine. She said registered nurse (RN) #4 was the only nurse who gave her the Excedrin Migraine, and no other nurses administered the medication. She said RN #4 worked the night shift three times per week and gave her Excedrin Migraine on those nights. Resident #39 said about one week ago she experienced a major migraine and suffered throughout the night until RN #4 gave her Excedrin Migraine.Resident #39 was interviewed again on 8/19/25 at 3:45 p.m. She said RN #4 administered two Excedrin Migraine tablets last night (8/18/25) for her migraine headaches and it relieved her pain.C. Record reviewReview of the March 2025 CPO revealed the physician's order for Excedrin Migraine was discontinued on 3/31/25.A nursing progress note, dated 3/7/25, revealed Resident #39 had been administered an Excedrin Migraine oral tablet 250-250-65 milligram (mg) as needed for migraine. The note documented the medication was ineffective and pain was rated 7 out of 10.A nursing progress note, dated 3/10/25, revealed Resident #39 refused her scheduled acetaminophen dose and said she would rather have Excedrin for her headache and the nurse was notified.A nursing progress note, dated 3/29/25, revealed administration of Excedrin Migraine oral tablet 250-250-65 mg. The note documented the as needed (PRN) administration was effective and the pain scale was zero.A physician progress note, dated 4/14/25, documented Resident #39 had a chronic history of headaches and reported Excedrin Migraine had previously helped her. The note documented Excedrin was discontinued because she also took anticoagulants. The physician documented Resident #39 was prescribed acetaminophen and Topamax (medication used to prevent migraine headaches) for pain management.A nursing progress note, dated 7/19/25, revealed the RN brought down two grocery bags containing a rotisserie chicken, a bottle of Tylenol and two bottles of Excedrin Migraine that the resident had purchased. The LPN removed the medications and secured them in the medication room. The RN informed Resident #39 that she could not bring medications into the facility.A behavior note by nursing staff, dated 7/22/25, revealed Resident #39 called her (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neurology clinic and requested a refill of her sumatriptan (a medication used to treat migraine headaches) and asked the physician to restart Excedrin Migraine. The neurology clinic informed the nurse they would not fill the sumatriptan and would not restart the Excedrin. The nurse documented that she informed the resident's nurse after the call.A physician progress note, dated 7/24/25, documented Resident #39 experienced frequent headaches and that she used sumatriptan for pain relief. The note documented continuation of topiramate, continuation of sumatriptan, use of acetaminophen as needed, and non-pharmacological pain relief.The pain management care plan, revised 8/2/24, documented Resident #39 had acute and chronic pain with episodic comfort concerns. Pertinent interventions included determining the resident's satisfactory pain level, educating the resident or representative on the pain management treatment plan, administering pain medications per order when non-medication interventions were ineffective and administering prescribed medication before activity and therapy.III. Staff interviewsRN #4 was interviewed on 8/19/25 at 4:30 p.m. She said the last time she gave Resident #39 two tablets of Excedrin Migraine was on 8/18/25. She said she usually documented medication administration, but she was busy and did not document it in the electronic medical record record. She said she wrote it on a piece of paper and later shredded it. She said she thought there was a physician's order for Excedrin Migraine and that was why she administered it. She said she was aware that Excedrin Migraine contained acetaminophen and caffeine. Certified nurse aide (CNA) #7 was interviewed on 8/19/25 at 5:13 p.m. She said she had not worked on the side of the hall where Resident #39 resided since the end of July 2025. She said she had administered sumatriptan for Resident #39's migraine symptoms because there was a physician's order. She said Resident #39 had asked her for Excedrin Migraine, but she did not administer it because there was not a physician's order.Primary care physician (PCP) #1 was interviewed on 8/20/25 at 12:04 p.m. She said staff should not give any medication without a physician's order because medications could interact with other prescribed medications. She said an Excedrin Migraine contains caffeine, which could increase heart rate, and contains acetaminophen, which could result in exceeding the resident's daily acetaminophen allowance if administered along with other acetaminophen orders. She said there must be a physician's order even for over the counter medications. She said the Excedrin Migraine was discontinued because it was not appropriate for long-term migraine treatment and the resident had difficulty sleeping when an Excedrin Migraine was administered in the evening. She said the pharmacy also recommended discontinuing the Excedrin Migraine because the resident was on anticoagulant therapy (medication used to prevent blood clots), which increased the risk of prolonged bleeding times. The director of nursing (DON) and regional clinical resource (RCR) #1 were interviewed together on 8/20/25 at 12:45 p.m. The DON said it was not acceptable for a nurse to administer medications without a physician's order. The DON said a physician's order was required because the physician must be aware of the resident's history. She said giving medications without physician's orders could cause interactions with other medications or could cause allergic reactions.RCR #1 said she was not sure why RN #4 administered an Excedrin Migraine without a physician's order and said the facility could not go back in time and fix the incident, but moving forward they would re-educate staff. She said the plan of correction would include educating staff not to give medications without physician's orders, identifying the incident as a medication error, reporting it, and taking disciplinary action. She said medication pass would be monitored and a stat (immediate) prothrombin time/international normalized ratio (PT/INR) (a blood test that measures clotting time) would be completed to ensure the resident was not over-anticoagulated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure proper treatment and services to maintain vision abilities for one (#8) of three residents reviewed for vision services out of 45 sample residents.Specifically, the facility failed to ensure Resident #8's new eyeglasses were obtained in a timely manner and the resident was scheduled for a cataract surgery consultation. Findings include:I. Facility policy and procedureThe Hearing and Vision Services policy, revised April 2025, was provided by the chief nursing officer on 8/20/25 at 2:48 p.m. It read in pertinent part, It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. The social worker/social services designee is responsible for assisting residents, and their families in locating and utilizing any available resources (Medicare or Medicaid program payment, local health organizations offering items and services which are available free to the community), for the provision of the vision and hearing services the resident needs. Once vision or hearing services have been identified, the social worker/social services designee will assist the resident by making appointments and arranging for transportation.II. Resident #8A. Resident statusResident #8, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included schizophrenia (mental illness) , severe obesity, emphysema (lung disease) and Parkinson's disease. The 6/19/25 minimum data set (MDS) assessment revealed the resident had a moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. He required supervision with eating and bathing and moderate assistance with personal hygiene and dressing.The MDS assessment documented the resident had impaired vision requiring corrective lenses.B. Resident observation and resident representative interviewResident #8's representative was interviewed on 8/18/25 at 11:15 a.m. The representative said Resident #8's eyeglasses were very old and needed replacement.On 8/20/25 at 10:15 a.m., Resident #8 was sitting in his bed dressed and groomed. The resident was not wearing glasses.C. Record reviewResident #8's care plan did not reveal documentation regarding Resident #8's visual needs.Resident #8's last eye exam note was dated 8/20/24. The optometrist documented the resident needed to be seen by an ophthalmologist (eye specialist) for a cataract exam. The note documented the resident's glasses improved his vision somewhat, so a prescription would be provided today, but for best visual outcome a cataract surgery may be needed. The exam note documented a new order to dispense the new prescription and a referral for a cataract exam. -Review of Resident #8's electronic medical record (EMR) on 8/20/25 did not reveal documentation to indicate the resident's eyeglasses had been ordered or he had received his new eyeglasses. There was also no documentation indicating a referral had been made to an ophthalmologist for a cataract exam. D. Staff interviewsCertified nurse aide (CNA) #4 was interviewed on 8/20/25 at 9:50 a.m. CNA #4 said Resident #8 had old prescription glasses. CNA #4 said the resident had the same glasses for several years. CNA #4 said Resident #8 was unable to see very well.Licensed practical nurse (LPN) #1 was interviewed on 8/20/25 at 10:00 a.m. LPN #1 said Resident #8 used to wear prescription eyeglasses, but she had not seen him wear them in a while.The social services director (SSD) was interviewed on 8/20/25 at 10:56 a.m. The SSD said the facility had recently identified vision services were one of the areas that needed a process correction. The SSD said she had contacted and was working to get optometry services at the facility. The SSD said an audit of residents for ancillary services needs, including vision needs, was completed in June 2025 by the regional clinical resource (RCR). The SSD said she did not know if Resident #8 required a consult for cataract surgery or a new prescription for eyeglasses as she had not seen the 8/20/24 eye exam provider note. The SSD said she was not certain if Resident #8's medical record had been audited for his vision needs. The SSD said she would follow up to determine Resident #8's vision needs. The SSD said residents could experience stress if they could not get new eyeglasses or have their vision corrected in a timely manner.The director of (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing (DON) was interviewed on 8/20/25 at 3:35 p.m. The DON said ancillary services, including vision services were identified as an area of concern for residents by the RCR and herself. She said the facility was developing a performance improvement plan to address the concerns. The DON said when the facility received orders from the vision provider which included a follow up appointment, the next day the scheduler should make arrangements for appointments. The DON said once the facility obtained a prescription for a resident's eyeglasses she would expect to arrange for ordering the eyeglasses within a few days and the resident should expect to receive new eyeglasses in less than a month. The DON said it was important for residents to have eye issues addressed to enhance their well-being and to prevent falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#66) of three residents reviewed for respiratory care out of 45 sample residents were provided respiratory care consistent with professional standards of practice.Specifically, the facility failed to ensure cleaning and proper care of Resident #66's CPAP (continuous positive airway pressure) machine according to manufacturer's instructions and per physician's orders.Findings include:I. Manufacturer's instructionsThe ResMed AirSense 10 CPAP Machine user guide was provided by the nursing home administrator (NHA) on 8/19/25 at 3:08 p.m. It read in pertinent part, Daily cleaning: Disconnect the air tubing and mask, and wash the mask (including cushion and frame) in warm water with mild detergent. Rinse all parts thoroughly and allow to air dry away from direct sunlight. Wipe the exterior of the device with a dry cloth. Empty the humidifier tub daily, rinse it thoroughly in warm water, and allow it to air dry out of direct sunlight. Weekly cleaning: Wash the humidifier tub and air tubing in warm water with mild detergent. Rinse well and allow to air dry out of direct sunlight. Filter maintenance: Check the air filter every month for holes or blockages by dirt or dust. Replace the filter at least every six months, or more often if necessary. The filter is not washable or reusable. Do not use: Bleach, alcohol, chlorine-based solutions, moisturizing or antibacterial soaps, scented oils, or harsh cleaners. Do not place any parts in a dishwasher, washing machine, or expose them to direct sunlight for drying. Replacement schedule (general guidelines): Replace the air filter every six months, the humidifier tub every six months (or as needed if cracked, leaking, or discolored), the tubing every six to 12 months, and the mask system (frame, cushion, headgear) every six to 12 months, depending on wear.II. Resident #66A. Resident statusResident #66, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure with hypoxia (low oxygen levels in the blood), obstructive sleep apnea (pauses in breathing during sleep caused by airway blockage) and mild persistent asthma with status asthmaticus (ongoing airway inflammation with episodes of severe asthma attacks).The 8/14/25 minimum data set (MDS) assessment revealed Resident #66 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required set-up or clean-up assistance with eating and oral hygiene. She was dependent on staff for toileting, bathing and dressing. She required moderate assistance with mobility.B. Resident interview and observationsResident #66 was interviewed on 8/17/25 at 4:41 p.m. Resident #66 said her CPAP mask was normally kept in the drawer of her nightstand, but she did not know why there were two other masks on the countertop in the bathroom. She said at night, the staff handed her the CPAP mask and she put it on herself. She said she took the CPAP mask off in the morning, placed it on her bed and the staff put it in the drawer. She said she had not seen the staff wash her CPAP mask.On 8/17/25 at 4:50 p.m. Resident #66's CPAP machine, along with one mask, was observed next to the resident's bed on the nightstand. Two CPAP masks were observed in the resident's bathroom sink in the space next to each faucet handle with no towel underneath. On 8/18/25 at 8:45 a.m., the resident's CPAP mask was observed on the nightstand next to the bed, attached to the CPAP machine. Two other CPAP masks were observed on the side of the bathroom sink. Resident #66 said the staff did not wash the CPAP mask. On 8/19/25 at 8:34 a.m. Resident #66's CPAP mask was observed on the nightstand next to the resident's bed. Two other CPAP masks were observed on the side of the bathroom sink. Resident #66 said she had asked the respiratory therapist the day before how often he changed the mask and tubing, and he told her once a week. She said she had never seen staff wash the CPAP mask. C. Record reviewA review of Resident #66's CPAP care plan, initiated 8/3/23 and revised 10/21/24, revealed the resident had oxygen therapy related to respiratory failure. Pertinent interventions included monitoring for signs and symptoms of respiratory distress. -The care plan failed to include cleaning frequency or instructions for the CPAP machine and its parts.A review (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident #66's August 2025 CPO revealed the following physician's orders related to the resident's CPAP machine: CPAP 5-20 centimeter (cm) HˆO (machine delivers airway pressure adjustable between 5 and 20 cm of water pressure) with 2 liters L oxygen at bedtime for obstructive sleep apnea, ordered 8/9/24.CPAP mask cleaning: place in warm, soapy water, soak/agitate for five minutes, rinse and air dry between uses, every day shift, ordered 9/21/24. A review of the June 2025 through August 2025 medication administration record/treatment administration records (MAR/TAR) revealed staff consistently documented completion of daily CPAP mask cleaning.-However, observations and staff interviews revealed the resident's CPAP mask had not been cleaned or washed as ordered (see observations and resident interview above and staff interviews below). -Additionally, Resident #66 said staff did not clean or wash the CPAP mask on a daily basis (see resident interview above).III. Staff interviewsThe director of nursing (DON) was interviewed on 8/19/25 at 12:48 p.m. The DON said the process when a resident was done using the CPAP machine in the morning was for staff to wash the CPAP mask with soap and water and place it on a towel to dry in order to avoid bacterial infection. She said staff should have followed the physician's order for cleaning recommendations for Resident #66's CPAP mask. She said bacteria were important to avoid because they could get into the lungs and cause infections. She said she expected staff to clean Resident #66's CPAP mask daily. She said the respiratory therapist changed the CPAP tubing every Monday. She said she would re-educate staff and train them to wash and clean the resident's CPAP mask daily.On 8/19/25 at 12:50 p.m. the DON observed the CPAP masks in Resident #66's room on the side of the sink and next to the resident's bed. The DON said the storage of the masks was not acceptable and she would educate staff.Certified nurse aide (CNA) #8 was interviewed on 8/20/25 at 9:59 a.m. CNA #8 said she just put Resident #66's CPAP mask on and took it off the resident's face and did not clean it. She said the nurses were responsible for cleaning and completing maintenance for CPAP machines. CNA #5 was interviewed on 8/20/25 at 10:02 a.m. CNa #5 said she was not too familiar with CPAPs and sometimes she put the CPAP mask on and took it off the resident's face. She said she did not know who cleaned the CPAP masks.Registered nurse (RN) #1 was interviewed on 8/20/25 at 10:16 a.m. RN #1 said she first checked if a resident's CPAP mask was clean, and then she checked if there was distilled water in the chamber and if the machine was working properly. She said she helped the resident put the mask on if assistance was needed. For cleaning, she said she checked to see if there was any residue, mucus, or dirt in the CPAP mask. She said if she noticed residue, she cleaned it or replaced it. RN #1 said she tried to pay attention to Resident #66's CPAP whenever she was in the room. She said she did not know how often the mask should have been cleaned. She said in the past two days she had noticed the mask in Resident #66's nightstand and it was clean, but no cleaning had been done in those two days. She said if she noticed dirt or residue on the mask, she used gauze with saline water or distilled water to wipe and clean the mask and then let it air dry. She said she was not aware that there were two CPAP masks in Resident #66's bathroom sink. She said she did not know if Resident #66's CPAP mask should be washed with warm soapy water because she was taught in the hospital not to use tap water, as the water source was unknown and bacteria could build up.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents who required dialysis services received such services consistent with professional standards for one (#3) of two residents reviewed for dialysis out of 45 sample residents. Specifically, for Resident #3, the facility failed to: -Consistently and thoroughly complete the dialysis communication forms between the facility and the dialysis center; and, -Collaborate with the dialysis facility regarding dialysis care and services, specifically acknowledging a recommendation for a gastroenterology referral and medication changes made on the dialysis communication forms. Findings include:I. Facility policy and procedure The Hemodialysis policy and procedure, revised 4/11/25, was provided by the chief nursing officer on 8/20/25 at 3:07 p.m. It read it pertinent part, The facility will coordinate and collaborate with the dialysis facility to assure that there is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff. The facility will immediately contact and communicate with the attending physician, resident/representative any significant changes in the resident's status related to clinical complications or emergent situations that may impact the dialysis portion of the care plan. The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications.II. Resident #3A. Resident status Resident #3, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included chronic kidney disease with heart failure, chronic respiratory failure, type 2 diabetes mellitus, idiopathic aseptic necrosis of the right hand (condition where the bone tissue in the right hand dies due to a lack of blood supply with no identifiable cause), dependence of renal dialysis, systemic lupus erythematosus, acquired absence of the right leg below the knee, depression and anxiety. According to the 7/15/25 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She had an impairment in one upper extremity and used a wheelchair. She required set up assistance with eating, and she was dependent on staff assistance for toileting and showering. She required substantial assistance with oral hygiene and personal hygiene. The MDS assessment indicated the resident received dialysis treatments.B. Resident interview Resident #3 was interviewed on 8/19/25 at 9:26 a.m. Resident #3 said she had abdominal cramping when she went to dialysis. She said the abdominal cramping was so bad that she asked the dialysis center to stop her dialysis early. She said she had had abdominal cramping for about nine months. She said she often asked the dialysis facility to cut her dialysis treatment sessions short because of the abdominal pain. She said she knew she needed dialysis to live, but sometimes she felt it was better not to have dialysis, so she did not have abdominal pain. She said she was supposed to see a gastroenterologist. She said she did not remember when the specialist was recommended, but it had been a while. She said the facility was working on it, and she did not know why it was taking so long to get an appointment with the gastroenterologist. C. Record review Review of Resident #3's dialysis care plan, initiated 1/24/25, revealed the resident received dialysis related to renal failure. Interventions included going to dialysis three times a week, monitoring for any signs and symptoms of infection to the dialysis access site, and working with the resident to relieve discomfort from the side effects of the disease and treatment. -However, the care plan did not include monitoring the resident's vital signs and weights pre- and post-dialysis treatment. Review of Resident #3's August 2025 CPO revealed the following physician's orders related to dialysis: Dialysis - access site central site. Central venous catheter to the right chest, ordered 1/22/25.Resident to have dialysis Monday, Wednesday and Friday and as needed, ordered 1/22/25. Check the graft site (dialysis access site), ordered 1/22/25. Resident #3's dialysis communication forms were reviewed from 7/2/25 to 8/13/25. Each log had three sections on one sheet of paper, which revealed the following: The first section of the communication form was to be filled in by the facility before (continued on next page)

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Sterling Rehabilitation and Nursing, LLC	1420 S 3rd Ave Sterling, CO 80751

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis with the resident's name, the dialysis date, vital signs, which included temperature, pulse, respirations, blood pressure and oxygen saturation levels and dialysis access site assessment. There was also a section to describe any other concerns. A facility nurse's signature and time the resident left the facility were required.The second section of the communication form was to be filled out by the dialysis center staff. The documentation included the resident's vital signs, the time dialysis started and ended, the resident's weight pre- and post-dialysis, labs drawn, medications given and any other concerns. A dialysis staff person's signature and title were required. The third section of the communication form was to be filled in by the facility after dialysis with the resident's vital signs, dialysis access site assessment, including if the dressing was in place, if there was abnormal bleeding and any other concerns. A facility nurse's signature and the time the resident returned to the facility were required. Review of Resident #52's dialysis communication forms from 7/2/25 to 8/13/25 documented the following: The pre-dialysis section for the dialysis access site assessment and the nurse's signature was left blank on the following dates: 7/4/25, 7/16/25, 7/18/25, 7/23/25 and 7/25/25.The 7/16/25 dialysis section of the form revealed to discontinue Resident #3's milk of magnesia physician's order due to its contraindication in hemodialysis patients and give Miralax or lactulose. It documented milk of magnesia could cause hypermagnesemia, which hemodialysis patients could not clear from their system correctly. The dialysis section of the 7/16/25 communication form further revealed the resident's dialysis treatment ended early due to cramping.The dialysis section of the forms revealed Resident #3 experienced abdominal pain and cramping on the following dates: 7/18/25, 7/25/25, 8/1/25, 8/4/25, 8/6/25, 8/8/25 and 8/13/25. The dialysis section of the forms revealed the resident ended dialysis treatment early on the following dates: 8/1/25, 8/4/25, 8/6/25 and 8/8/25. The 8/4/25 dialysis section of the form revealed Resident #3 ended dialysis treatment 65 minutes early due to abdominal cramping. The resident reported cramping all the time and not just with dialysis. The form instructed that the resident needed a gastroenterology consultation. The post-dialysis section of Resident #3's dialysis communication form was left blank in its entirety on 7/2/25, 7/25/25, 7/28/25, 8/1/25, 8/6/25 and 8/13/25.Review of Resident #3's August 2025 CPO revealed the following physician's order: Milk of magnesia. Take 30 milliliters (ml) by mouth every 24 hours as needed for constipation. Use on day three of no bowel movement, ordered 7/4/25. -A review of Resident #3's electronic medical record (EMR) revealed the facility failed to follow the dialysis center's recommendation to discontinue the resident's milk of magnesia due to its contraindicated use in hemodialysis patients.-A review of Resident #3's EMR failed to identify documentation to indicate the facility was following up on the dialysis center's recommendation to schedule the resident for a gastroenterology consultation due to her persistent abdominal cramping. III. Staff interviews Registered nurse (RN) #1 was interviewed on 8/20/25 at 10:31 a.m. RN #1 said when a resident went to dialysis, they were sent with a folder that included a communication form. She said the communication form had three sections and she said she filled out the top section before the resident went to dialysis. She said she was responsible for obtaining the resident's pre-dialysis vital signs and making sure the dialysis access site was intact. She said she documented the information on the dialysis communication form. RN #1 said the communication form went with the resident to dialysis. She said the dialysis center was responsible for completing the middle section of the communication form. RN #1 said when the resident returned from dialysis, she was responsible for obtaining the resident's vital signs and making sure the dialysis access site was intact. She said she documented the information on the third section of the communication form. She said if the resident came back with new physician's orders or recommendations, she verified the orders with the facility's physician and then entered the orders into the resident's EMR. She said once the dialysis communication form was completed, the form was placed in a file at the nurses' station for the medical records person to pick up so they could scan the form into the resident's EMR. RN #1 said she was familiar with Resident #3. She said Resident #3 went to dialysis. She said Resident #3 ended dialysis early because of abdominal cramping. RN #1 said the abdominal cramping usually (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resolved on its own or she gave the resident Zofran (an anti-nausea medication). RN #1 said she heard the resident once say if the abdominal pain was going to continue, she did not want to have dialysis. RN #1 said she overheard it in the hallway when she was assigned to another hallway and she did not follow up on the resident's comment. RN #1 said she did not know there was a recommendation from the dialysis facility for a gastroenterology consultation for Resident #3. The director of nursing (DON) was interviewed on 8/20/25 at 4:04 p.m. The DON said when a resident went to dialysis, the resident was sent with a folder that included a dialysis communication form. She said the communication form had three sections and the facility's unit nurse filled out the top section before the resident went to dialysis. The DON said the facility nurse was responsible for obtaining the resident's pre-dialysis vital signs and making sure the dialysis access site was intact. The DON said the unit nurse documented the information on the dialysis communication form. She said the dialysis communication form went with the resident to dialysis. She said the dialysis center was responsible for completing the middle section. The DON said when the resident returned from dialysis, the unit nurse was responsible for obtaining the resident's vital signs and making sure the dialysis access site was intact. The DON said the unit nurse asked how the resident was doing after dialysis and if they needed any medications. The DON said the unit nurse was responsible for reading the dialysis section of the communication form to see if there were any changes to any physician's order, including medications and blood work. She said the dialysis communication form was scanned and uploaded to the resident's EMR by the medical records department. She said if a resident came back from dialysis with new physician's orders or recommendations, the facility nurse verified the orders with the facility's physician and then entered the orders into the resident's EMR. She said once the dialysis communication form was completed, the form was placed in a file at the nurses' station for medical records to pick up so they could scan the form into the resident's EMR. The DON said she was familiar with Resident #3. She said she went to dialysis and she knew she sometimes ended dialysis early because she was nauseous and was vomiting. She said she gave Resident #3 Zofran, offered for the resident to lie down and put a bag next to her bed in case she vomited. The DON said she was aware the resident complained about abdominal pain from dialysis. The DON said the physician was notified of the abdominal pain and orders were given. The DON said she was not aware the dialysis center documented the need to obtain a gastroenterology consultation for Resident #3. She said if there was a gastroenterology consultation recommendation, the nurse who reviewed the dialysis communication form should have entered a physician's order in the resident's EMR for the consultation. She said the physician's order was how the scheduler knew what appointments needed to be made for residents. She said the scheduler made appointments within the same day the physician's order was entered, if not the following day. She said if the dialysis center documented the need for Resident #3 to have a gastroenterology consultation on 8/4/25, the physician's order should have been in the resident's chart by now (8/20/25) and the facility should have known the status of the consultation appointment. The DON said she did not know there was a recommendation to stop Resident #3's milk of magnesia physician's order and she did not know some of the resident's dialysis communication forms were incomplete.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for three of three certified nurse aides (CNA).Specifically, the facility failed to complete annual performance reviews and/or provide regular in-service education based on the outcome of the reviews for CNA #1, CNA #2 and CNA #3.Findings include:I. Record reviewAnnual performance reviews for CNAs were requested on 8/18/25 at 4:56 p.m. for CNA #1, CNA #2 and CNA #3. The facility was unable to provide annual performance evaluations for CNA #1 (hired 10/25/16), CNA #2 (hired 4/8/22) and CNA #3 (hired 6/26/23). -The CNAs did not have an annual performance review completed and the CNAs did not have an in-service education plan based on the outcome of the review.II. Staff interviewsThe director of nursing (DON) and regional clinical resource (RCR) #1 were interviewed together on 8/19/25 at 2:36 p.m. The DON said the annual performance evaluations should be completed annually. The DON said it was important because if a CNA needed retraining, then she could provide training and also refresh their memory on skills. The DON said a competency assessment during the review was important to ensure the facility was providing the best care to the residents.RCR #1 said the human resources department was looking for the annual performance reviews because the reviews were not kept in her office but she would continue to look.On 8/19/25 at 3:53 p.m. the RCR said the human resources department could not find the annual performance evaluations for CNA #1, CNA #2 and CNA #3.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to ensure the medication error rate was less than five percent (%).Specifically, the facility had a medication error rate of 11.53 percent, which was three errors out of 26 opportunities for error.Findings include:I. Professional referencesAccording to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), Elsevier, St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environmentˆ.ˆ ˆˆProfessional Standards such as nursing scope ˆand standards of practice apply to the activity of medication administrationˆ. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. ˆMany medication errors ˆcan be linked ˆin some way to an inconsistency ˆin adhering to these seven rightsˆ: 1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.According to the manufacturer Novo Nordisk , NovoLog (insulin aspart), February 2023, Instructions for Use, retrieved 8/25/25 from https://www.novo-pi.com/novolog.pdf, Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:Turn the dose selector to select two units, hold your NovoLog Flex Pen with the needle pointing up, tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upward, press the push-button all the way in. The dose selector returns to zero. A drop of insulin should appear at the tip.According to the manufacturer Sanofi-Aventis, Lantus Solostar (insulin glargine), May, 2025, Instructions for Use, retrieved on 8/25/25 from https://products.sanofi.us/Lantus/Lantus.pdf, Always do a safety test before each injection to check your pen and the needle to make sure they are working properly and make sure that you get the correct Lantus dose. Select two units by turning the dose selector until the dose pointer is at the two mark. Press the injection button all the way in. When insulin comes out of the needle tip, your pen is working correctly.II. Facility policy and procedureThe Medication Administration policy, revised August 2025, was provided by the nursing home administrator (NHA) on 8/19/25 at 1:02 p.m. It read in pertinent part, Administer medication as ordered in accordance with manufacturer specifications. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action.III. Observations and record review On 8/19/25 at 11:01 a.m., registered nurse (RN) #1 was observed preparing to administer an inhaler medication to Resident #38.The physician's orders for Resident #38 read, Fluticasone proprionate/salmeterol inhaler 250 micrograms (mcg)/50 mcg, one puff twice a day, rinse mouth with water after use.RN #1 brought the inhaler to Resident #38 to administer the medication. Resident #38 took one puff from the inhaler. RN #1 then walked away from the resident.-RN #1 failed to have Resident #38 rinse out his mouth after taking a puff from the inhaler.On 8/19/25 at 4:55 p.m. registered nurse (RN) #3 was observed preparing two insulin medications for Resident #20, insulin aspart and insulin glargine. The physician's orders for Resident #20 read, NovoLog Injection solution (Insulin Aspart), 100 units per milliliter (ml), inject 24 units subcutaneously with meals for diabetes mellitus type two. Insulin Glargine subcutaneous solution 100 units per ml, inject 47 units subcutaneously two times per day for diabetes mellitus.RN #3 obtained Resident #20's insulin pens from the medication cart, cleaned the tip of the insulin aspart pen with an alcohol pad, applied a new needle and then dialed the insulin pen to 24 units. She then cleaned the tip of the insulin glargine pen with an alcohol pad, applied a new needle and dialed the insulin pen to 47 units. RN #3 entered Resident #20's room, advised the resident of the insulin medications, cleaned the resident's abdomen on the left side with an alcohol swab, removed the safety cap and administered the injected medications consecutively. -RN #3 failed to perform a safety test by priming the resident's insulin pens per manufacturer's directions (see professional reference above) prior to administering the medication.Cross- reference F760 failure to ensure (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents were free from a significant medication error.IV. Staff interviewsRN #3 was interviewed on 8/19/25 at 5:10 p.m. RN #3 said she thought she primed the insulin pens for Resident #20 prior to attaching the needle tips onto the pens. RN #3 was not able to verbalize the reason it was important to attach the needle to the pen prior to priming the insulin pen.RN #1 was interviewed on 8/19/25 at 5:30 p.m. RN #1 said she should have asked Resident #38 to rinse his mouth with water after he used the inhaler as the medication tasted bad. The director of nursing (DON) was interviewed on 8/20/25 at 12:40 p.m. The DON said RN #3 should have primed the insulin pens to make sure there was no air in the pens and to ensure the right dose of insulin would be administered to Resident #20. The DON verbalized the process of priming the insulin pen. The DON said if insulin pens were not primed the resident could receive less insulin than what was ordered. The DON said RN #1 should have asked Resident #38 to rinse his mouth with water after he used the inhaler.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#20) of two residents reviewed for insulin administration out of 45 sample residents was kept free from significant medication errors.Specifically the facility failed to ensure insulin pens were primed prior to two insulin medication administrations for Resident #20.Findings include:I. Professional referenceAccording to the manufacturer Novo Nordisk , NovoLog (insulin aspart), February 2023, Instructions for Use, retrieved 8/25/25 from https://www.novo-pi.com/novolog.pdf, Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:Turn the dose selector to select two units, hold your NovoLog Flex Pen with the needle pointing up, tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upward, press the push-button all the way in. The dose selector returns to zero. A drop of insulin should appear at the tip.According to the manufacturer Sanofi-Aventis, Lantus Solostar (insulin glargine), May, 2025, Instructions for Use, retrieved on 8/25/25 from https://products.sanofi.us/Lantus/Lantus.pdf, Always do a safety test before each injection to check your pen and the needle to make sure they are working properly and make sure that you get the correct Lantus dose. Select two units by turning the dose selector until the dose pointer is at the two mark. Press the injection button all the way in. When insulin comes out of the needle tip, your pen is working correctly.II. Facility policy and procedureThe Medication Administration policy, revised August 2025, was provided by the nursing home administrator (NHA) on 8/19/25 at 1:02 p.m. It read in pertinent part, Administer medication as ordered in accordance with manufacturer specifications.III. Resident #20 A. Resident statusResident #20, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included diabetes and chronic kidney disease.The 5/23/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. He required set up assistance with eating and dressing, and supervision with toileting and showering. B. Record reviewReview of Resident #20's August 2025 CPO revealed the following physician's orders:NovoLog Injection solution (Insulin Aspart), 100 units per milliliter (ml), inject 24 units subcutaneously with meals for diabetes mellitus type two, ordered 5/13/25.Insulin Glargine subcutaneous solution 100 units per ml, inject 47 units subcutaneously two times per day for diabetes mellitus, ordered 5/6/25.C. ObservationsOn 8/19/25 at 4:55 p.m. registered nurse (RN) #3 was observed preparing two insulin medications for Resident #20, insulin aspart and insulin glargine. RN #3 obtained the resident's insulin pens from the medication cart, cleaned the tip of the insulin aspart pen with an alcohol pad, applied a new needle and then dialed the insulin pen to 24 units. She then cleaned the tip of the insulin glargine pen with an alcohol pad, applied a new needle and dialed the insulin pen to 47 units. RN #3 entered Resident #20's room, advised the resident of the insulin medications, cleaned the resident's abdomen on the left side with an alcohol swab, removed the safety cap and administered the injected medications consecutively. -RN #3 failed to perform a safety test by priming the resident's insulin pens per manufacturer's directions (see professional reference above) prior to administering the medication.Cross-reference F759 failure to ensure the medication error rate was less than five percent. IV. Staff interviewsRN #3 was interviewed on 8/19/25 at 5:10 p.m. RN #3 said she thought she primed the insulin pens prior to attaching the needle tip onto the pens. RN #3 was not able to verbalize the importance of priming the insulin pens.The director of nursing (DON) was interviewed on 8/20/25 at 12:40 p.m. The DON said RN #3 should have primed the insulin pens to make sure there was no air in the pens and to ensure the right dose would be administered to Resident #20. The DON said if insulin pens were not primed, the resident could receive less insulin than what was ordered. The DON said RN #1 should have asked Resident #38 to rinse his mouth with water after he used the inhaler.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#8 and #39) of two residents reviewed for ancillary services out of 45 sample residents received routine dental care and 24-hour emergency dental care.Specifically, the facility failed to:-Ensure Resident #8 was provided timely dental services to repair his of dentures; and, and-Ensure Resident #39 was provided a routine dental appointment. Findings include: I. Facility policy and procedure The Dental Services policy, revised April 2025, was provided by the chief nursing officer on 8/20/25 at 2:48 p.m. It read in pertinent part, It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor, partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, taking impressions for dentures and fitting dentures. For residents with lost or damaged dentures, the facility will refer the resident for dental services within three days. II. Resident #8 A. Resident status Resident #8, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included schizophrenia (mental illness), severe obesity, emphysema (lung disease) and Parkinson's disease. The 6/19/25 minimum data set (MDS) assessment revealed the resident had a moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. He required supervision with eating and bathing and moderate assistance with personal hygiene and dressing. The MDS assessment revealed the resident had no issues with his dentures, including no pain, discomfort or difficulty chewing and no broken or loosely fitting dentures. -However, Resident #8's representative and staff interviews revealed Resident #8 had ill fitting dentures for several months (see interviews below). B. Resident #8's representative interview and observation Resident #8's representative was interviewed on 8/18/25 at 11:39 a.m. The representative said Resident #8 had not been able to wear his dentures for a long time as they did not fit right and they needed to be adjusted. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/25 at 10:15 a.m. Resident #8 was dressed, groomed and sitting in bed. Resident #8's dentures were in a plastic container located on the sink in his bathroom. C. Record review The dental care plan, revised 6/23/25, revealed Resident #8 had dentures that he often refused to wear. The interventions included dental services to be provided as needed, help Resident #8 brush his dentures, monitoring for pain or discomfort related to dentures and notifying the nurse of any concerns. -A review of Resident #8's care plan did not reveal the dentures were not fitting correctly. Resident #8's last dental consultation was dated 2/13/23 and recommended a follow up visit in one year, or sooner if denture adjustments were needed. -Resident #8 had not been seen for a dental consultation in two and a half years. D. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 8/20/25 at 9:55 a.m. CNA #4 said Resident #8 had not worn his dentures in months because they did not fit him correctly. CNA #4 said Resident #8 needed a dental appointment to fix the dentures. CNA #4 said the nurses and the scheduler were aware that Resident #8 needed a dental appointment, but the appointment had not been scheduled. The social services director (SSD) was interviewed on 8/20/25 at 10:56 a.m. The SSD said Resident #8's last dental exam was in February 2023. The SSD said she was not aware that Resident #8 did not wear his dentures. She said the facility recently identified many denture wearing residents who were having issues with the fit of their dentures. The SSD said if a resident was having issues with their dentures, she would expect a referral to be initiated within a few days, and the consultation to occur within one month. The SSD said the facility had begun to arrange monthly dental visits onsite. The director of nursing (DON) was interviewed on 8/20/25 at 3:40 p.m. The DON said she had not seen Resident #8 wear his dentures for several months. The DON said she was not certain why Resident #8 did not wear his dentures. The DON said when residents had issues with teeth or dentures, she expected the CNAs to notify the nurse, and the nurse would notify the DON and the SSD to make an appointment. The DON said ancillary services, such as dental appointments, were an area that had been identified in June 2025 by the DON and regional clinical resource (RCR) #1 as needing improvement and the facility was creating a performance improvement plan to address ancillary services issues. The DON said she would confirm the SSD had made a dental appointment for Resident #8. The DON said it was important for residents to have functioning dentures to enable them to eat and promote resident dignity. III. Resident #39 A. Resident status Resident #39, age [AGE], was admitted on [DATE]. According to the August 2025 CPO, diagnoses included insufficient sleep syndrome (sleep disorder where a person does not get enough sleep), heart failure and type 2 diabetes mellitus without complications. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/26/25 MDS assessment documented the resident was cognitively intact with a BIMS score of 15 out of 15. She required set-up or clean-up assistance with bathing and eating. The MDS assessment documented the resident had obvious or likely had cavities or broken natural teeth. B. Resident interview Resident #39 was interviewed on 8/18/25 at 10:14 a.m. The resident said she had not been able to see a dentist since she was admitted to the facility on [DATE]. She said she had told the nursing staff and had also told the nurse practitioner (NP) six months ago that she wanted to see the dentist, but no one followed up. She said she was sick of no one getting back with her because she wanted to be able to eat salad but could not chew it. She said she received chicken noodle soup instead and could not eat sausage patties because they were too hard. During the interview Resident #39 had teeth that were broken and missing. Resident #39 was interviewed again on 8/19/25 at 3:45 p.m. The resident said it was painful when she ate and her gums swelled up and hurt. C. Record review The care plan initiated 8/7/24, documented Resident #39 had some missing and broken teeth. The goal was for the resident to maintain the ability to eat meals without dental pain or difficulty chewing. Interventions included referring the resident for dental services as needed, assessing for pain or discomfort related to dental issues and monitoring for changes in chewing or eating ability. The August 2025 CPO revealed the following physician's order: Resident may have a podiatrist, ophthalmologist, dentist and an audiologist as needed. ordered 1/22/25. -However, the CPO did not include a specific dental referral, dental consult, or a scheduled dental appointment. The social service progress note, dated 8/19/25 (during the survey), revealed Resident #39 had originally been referred to see a dentist in July 2025. The note documented that the dentist canceled the appointment due to a medical emergency and the appointment was rescheduled for 9/5/25. The SSD met with the resident and asked about discomfort and whether she felt she needed to be seen sooner. The resident denied pain, stating it only hurt when she chewed certain foods. The resident declined an emergency dental appointment but agreed to an urgent referral. The SSD contacted the ancillary coordinator, who sent an urgent referral form for completion. A review of the dental emergency evaluation form, dated 8/19/25, revealed the resident reported pain in the lower right area of her mouth. The form documented swelling was present, the resident reported a pain level of five and a half and the pain had been present for a few months. D. Staff interviews The SSD was interviewed on 8/19/25 at 2:50 p.m. The SSD said residents and their representatives (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be offered ancillary services upon admission and every quarter during the care plan conference. She said it should be documented in the progress notes when ancillary services were offered, scheduled, rescheduled or cancelled. She said she was unable to find documentation indicating Resident #39 had been offered dental services since the resident's admission on [DATE]. She said the Resident #39 had an appointment scheduled in August 2025 that was canceled due to the dentist's emergency, but she could not find documentation of that either. She said the process was that staff informed her of residents' dental needs and she recommended those services, either the in-house dentist who came monthly or referral to a community dentist based on the resident's preference. RCR #1 was interviewed on 8/19/25 at 3:05 p.m. She said the in-house dentist had been scheduled to come on 8/15/25 but could not due to a medical emergency and the appointment was rescheduled for 9/5/25. She said she talked with Resident #39 and Resident #39 did not want to go to the emergency room (ER) or be seen by an emergency dentist. She said the facility was in the process of completing a full-house audit of ancillary services, had identified several residents who needed ancillary services or had not seen a dentist and had written a plan of correction. RCR #1 said if paperwork and recommendations are not followed, it affects continuity of care and quality of care. She said she would initiate re-education of the staff. The DON was interviewed on 8/20/25 at 3:50 p.m. The DON said the plan to ensure residents received necessary dental care was to schedule an appointment, with the option of using the in-house dentist or an outside dentist. The DON said this was to help Resident #39 with chewing, addressed cavities, repaired broken teeth and prevented infection or other related dental issues.

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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. Based on observations and interviews the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection for one out of three units at the facility. Specifically, the facility failed to provide a bed bath for Resident #55 in a sanitary manner. Findings include: I. Facility policy and procedureThe Bed Bath policy and procedure, dated 4/11/25, was provided by the NHA on 8/19/25 at 7:37 p.m. It read in pertinent part, It is the practice of this facility to assist residents with bed bathing to maintain proper hygiene and help prevent skin issues. Equipment and supplies: gloves, washcloths, several towels, basin half filled with water, plastic trash bag or waste basket, lotion, and protective covering. Remove the resident's blanket and bedspread and place them on a clean surface; place a bath blanket over the top sheet and pull down the top sheet to the foot of the bed, leaving the bath blanket over the resident; Remove resident's clothing under the bath blanket while maintaining privacy and keeping them warm; Fill the basin halfway with water warm to the touch (between 98.6 Fahrenheit to 103 Fahrenheit). Have the resident feel the water to ensure it is comfortable for them; dip a washcloth into the water and wring out the excess water; form the washcloth into a mitt onto your gloved hand; wash the resident's eyes with water only, starting with the eye that is farther from you. With one corner of the washcloth, wash from the inner corner of the eye out towards the ear. Using another corner of the washcloth, repeat the process on the eye closest to you; wash the resident's face using soap or a facial cleanser only if the resident requests you to do so and rinse off all the soap and pat the skin dry. If the resident is able to assist, allow them to participate; Wash the resident's ears (behind the ears and gently inside the ears) and neck, rinsing and drying the areas; wash, rinse and dry the arms, underarms, and hands starting with the extremity farthest from you, exposing only the extremity you are working on. Repeat on the upper extremity closest to you; place a towel across the resident's chest and pull the bath blanket down to the resident's waist. Wash, rinse and dry the resident's chest and abdomen. Pay attention to the skin under breasts and/or any skin folds. Cover the chest with the bath blanket; expose the leg farthest from you and wash, rinse and dry the leg and foot, not forgetting to wash between the toes. Cover the leg and repeat the process on the leg closest to you, covering the leg when finished; assist the resident to turn to one side, keeping the resident covered with the bath blanket. Expose the back and buttocks and wash, rinse and dry the area; provide a backrub using the lotion, if the resident desires. Assist the resident back onto their back, keeping resident covered with the bath blanket; change the bath water in the basin, obtain a clean washcloth, perform hand hygiene and don new gloves;iIf the resident is able, provide bathing supplies and have them wash and dry perineal area. If unable, gain consent to clean perineal area; for females, expose the perineal area washing the pubic area with downward strokes from the front to the back; for males, expose the perineal area washing the penis from the urethral opening to the base of the penis, then the scrotum. Pull back the foreskin on uncircumcised males and clean under it, gently returning the foreskin; cover the resident with the bath blanket; place soiled linen in a bag for laundering; empty, rinse and dry the bath basin, returning it to its storage location; Remove and discard gloves and perform hand hygiene; apply any moisturizer to the resident's skin as needed; dress the resident in clean clothing; comb or brush the resident's hair; change bed linens; assist the resident to a comfortable position with call light in reach; document the procedure; inspect the skin along the way noting any open areas, bruising, or other signs of skin breakdown and notify the nurse if noted.II. ObservationOn 8/19/25 at approximately 2:00 p.m. CNA #1 and CNA #4 were observed providing a bed bath to Resident #55. The CNAs gathered supplies for the bed bath in advance and talked with the resident about the bath. The CNAs turned the resident side to side to remove bedding and placed a bath blanket under the resident. The CNAs said to Resident #55 at the beginning of the bath, we are going to work from the bottom up. They washed Resident #55's feet first, then his legs. CNA #4 then washed his perineal area including genitals and then washed his chest without changing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves. CNA #1 washed the resident's back and then his buttocks, she removed a small dressing from his sacral area. After washing his buttocks, CNA #1 reached into the water basin to obtain another washcloth, she ringed out the washcloth and then went to the resident's head of the bed, the washcloth was within a few inches of his face. Upon prompting CNA #1 stopped the bed bath. CNA #1 walked away from the bedside. CNA #1 removed her gloves. She took a towel and went to the bathroom, she used the sink to get it wet. CNA #1 then washed the resident's face and hair. After the bath, the resident said his skin and body were very sensitive to touch and turning.III. Staff interviewsCNA #5 was interviewed on 8/19/25 at 3:47 p.m. CNA #5 said she performed bed baths and learned how to complete a bed bath in CNA school. CNA #5 said she would get supplies first, and get two basins, one with water and one with soap and water and set up an area. CNA #5 said she would start at the head and work to the toes and wash the front of body first. CNA #5 said to use soap first and then rinse with water and dry off. CNA #5 said she would always work top to bottom but would skip the private areas to do last. CNA #5 said she would always end with the bottom area. CNA #5 said she would use lots of different washcloths about five or six and then dry. CNA #5 said she would apply lotion and then either redress or go get the nurse for a skin check if that was needed. The director of nursing (DON) and the NHA consultant were interviewed together on 8/20/25 at 3:05 p.m. The DON said a CNA performed a bed bath by first putting water in the pink bucket and making sure the temperature was good. She said the CNA would then get about 15 washcloths, body wash and prepare the resident. The DON said there should be one wash cloth for each area and to start at the face first working from head to toe. The DON said it was important to work head to toe and with different wash clothes to prevent contamination and be more hygienic. The DON said the CNAs needed to use the body wash first and then to rinse the area with the water. The DON said the water needed to be changed between every body part. The DON said for example one bucket of water for the face, then dump water, then each arm, chest, legs, back, feet and perineal area. The DON said the CNAs needed to always end with the perineal area for hygienic purposes and the bottom very last. The DON said the CNAs who did the bed bath for Resident #55 and started at the feet and worked to the face were not correct and it was not hygienic.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and interviews, the facility failed to ensure residents and their representatives had access to the most recent survey findings including survey results, certifications, complaint investigations and plans of correction.Specifically, the facility failed to ensure the survey findings binder was available, ensure staff members were aware of where the binder was located and ensure the binder was accessible for review.Findings include:I. Resident group interviewDuring the resident council group interview on 8/18/25 at 3:00 p.m., Residents, #19, #42, #45 and #61, who were cognitively intact, said they did not know where to access the survey findings binder.II. ObservationsOn 8/18/25 at 2:39 p.m. registered nurse (RN) #1 attempted to locate the survey findings binder at the nurses'station and at the front desk. RN #1 was unable to find the survey findings binder. The infection preventionist (IP) and the nursing home administrator (NHA) additionally attempted to locate the survey findings binder and were unable to find it.III. Staff interviewsRN #1 was interviewed on 8/18/25 at 2:40 p.m. RN #1 said she looked for the survey findings binder and could not find it, so she asked the IP to assist.The IP was interviewed on 8/18/25 at 2:43 p.m. The IP said she looked for the survey findings binder and could not find it.The NHA was interviewed on 8/18/25 at 2:45 p.m. The NHA said the facility was working on putting a survey findings binder together as he had not been able to find one in the facility.The chief nursing officer was interviewed on 8/18/25 at 2:55 p.m. The chief nursing officer said the facility staff had looked for the survey findings binder and could not find it. The chief nursing officer said the facility would resolve the issue and they would place the binder by the main entrance where it would be accessible to everyone.