STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46425 Based on interview and record review the facility failed to ensure residents had the right to request, refuse, and/or discontinue treatment, to participate in experimental research, and to formulate advance directives for 2 of 2 residents (Residents #4 and #63) reviewed for advanced directives. The facility failed to ensure Residents #4 and #63, who were listed as DNR had Out-of-Hospital Do Not Resuscitate (OOH-DNR) forms that did not have required information on the OOH-DNR. This failure could place residents at risk for not having their end of life wishes honored and incomplete records. Findings include: 1. Record review of Resident #4's, undated, face sheet reflected a [AGE] year-old-female who was admitted to the facility on [DATE], Resident #4 had diagnoses which included Chronic Obstructive Pulmonary Disease (lung disease that blocks airflow), kidney disease (damage to or disease of a kidney) Mental Disorder (a wide range of conditions that affect mood, thinking, and behavior), Major Depressive Disorder (persistently depressed mood), Cognitive Communication Disorder (difficulty communicating due to a disruption in cognitive processes such as attention, memory, and problem solving), and Psychotic Disorder (disconnection from reality). The face sheet reflected under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #4's physician order summary, dated 12/12/24, reflected the following order: DNR-Do Not Resuscitate, dated 11/29/20. Record review of Resident #4's care plan, dated 04/19/21, reflected a care plan for DNR. Record review of Resident #4's OOH-DNR form, dated 05/02/19, reflected there was no printed physician's name associated with the physician's signature. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #63's, undated, face sheet reflected an [AGE] year-old-male who was admitted to the facility on [DATE]. Resident #63 had diagnoses which included Alzheimer's Disease (progressive disease that destroys memory and other mental functions), heart disease (diseased vessels, structural problems, and blood clots), and Cognitive Communication Disorder (difficulty communicating due to a disruption in cognitive processes such as attention, memory, and problem solving) and dysphagia (difficulty swallowing). The face sheet also reflected under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #63's physician order summary, dated 12/11/24, reflected the following order: DNR-Do Not Resuscitate dated 02/20/24. Record review of Resident #63's care plan, dated 02/06/24, reflected a care plan for DNR. Record review of Resident #63's OOH-DNR form, date retrieved on 02/13/2024, reflected there was no indication of the relation of the qualified relative who signed the DNR. The qualified relative did not sign or date the bottom of the DNR. During an interview on 12/12/24 at 12:52PM with the SW, she stated an OOH DNR was not valid if it was not filled out correctly. She stated she was not responsible for auditing OOH-DNRs, the ADM was responsible for auditing OOH-DNRs. She stated there was missed information on OOH-DNRs for Residents #4 and #63. She stated there was no system for monitoring OOH-DNRs for accuracy. She stated the reason the DNR's were not completed correctly was human error. She stated there was no potential negative outcome for residents as the staff would review other forms in the residents' record to determine if a resident was a DNR or Full Code. During an interview on 12/13/24 at 12:20 PM with the ADM, she stated the OOH DNR was not valid if it was not filled out correctly. She stated the SW was responsible for making sure the OOH DNR was completed accurately. She stated they did not have a system in place to monitor OOH DNRs for accuracy. She stated the SW should be reviewing the OOH DNRs for accuracy. She stated there was missing information on the OOH DNR for Residents #4 and #63. She stated the missing information was due to human error. She stated the potential negative outcome was residents may not have their final wishes followed. She stated she was trained on how to complete an OOH DNR and her expectations were for them to be filled out completely and be correct . Record review of the Social Services Policies and Procedures Advanced Directives (Revised August 2023) reflected the following: Policy Statement Advance directives will be respected in accordance with state law and facility policy . Prior to or upon admission, the Social Services Director will inquire of the resident, his or her family members about the existence of any written advanced directives. Information about whether or not the resident has executed an advance directive shall be displayed in the medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If the resident indicated he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives . The team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Changes or revocation of a directive must be submitted in writing to the facility. The director of nurses or designee will notify the attending physician of advance directives as well as obtain appropriate orders. The licensed nurse will be required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of such directive . The Social Services Director will maintain a list of Residents with an Advanced Directive on file. A code status audit will be conducted by the DON or designee on a quarterly basis or designee on a quarterly or as needed basis. Record review of the facility's undated policy titled Advance Directives reflected no information regarding the creation of an OOH DNR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46425 Based on observation, interview and record review the facility failed to notify residents individually or through postings in prominent locations throughout the facility of the right to file grievances orally or in writing; the right to file grievances anonymously; the contact information of the grievance office with whom a grievance can be filed, that is, his or her name business address and business phone number, a reasonable expected time frame for completing the review of the grievance, and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system for 20 of 20 confidential residents reviewed for grievances . The facility failed to ensure 20 of 20 confidential residents were provided information of how to file a grievance, who the facility grievance official was and their right to obtain a written decision related to their grievance . This failure could place residents at risk of unresolved grievances and decreased quality of life. Findings include: Interviews and record review revealed 20 of 20 confidential residents, stated they did not have access to the Grievance form, they did not know they could file a Grievance anonymously, the Grievance procedure had never been discussed in Resident Council, and they had not observed a posting of the Grievance procedure in prominent locations. Residents attending Resident Council did not know where to acquire a grievance form, who to turn the form in to, and what happened once a grievance was filed. The residents did not know they had the right to receive a written decision once their grievance was resolved. Observation of prominent postings on 12/12/2024 at 12:30 PM revealed the facility did not include instructions regarding the grievance procedure with any of the prominent postings. Grievance forms were not available to residents and there was no access to submit a grievance anonymously. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the ADM on 12/12/2024 at 11:35 AM, the ADM stated she was the Grievance Officer for the facility. The ADM stated she and Social Services shared the responsibility of reviewing Grievances and assigned them to department heads. The ADM stated the Grievance form was kept in the Social Worker's office. The ADM stated the residents did not have access to the Grievance form. The ADM stated there used to be a box in the hallway with Grievance forms in it, but it had since fallen off the wall, had not been replaced, and residents in wheelchairs were not able to reach the Grievance forms in the box. The ADM stated staff completed Grievance forms for residents, residents did not ask for forms or complete them on their own. The ADM stated there were no procedures for residents to submit grievances anonymously. The ADM stated the facility had 72 hours to resolve grievances once they were submitted. The ADM stated Social Services assigned the grievance to the appropriate department, that department addressed the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant . The resolutions were documented on the grievance form and the completed form was submitted to the ADM for review. The ADM stated completed grievance forms were kept in a notebook for 3 plus years. The ADM stated she monitored the grievance process for success by following up with the staff member assigned to resolve the grievance. The ADM stated she also met with the complainant to ensure they were satisfied with the resolution. The ADM stated she was responsible for ensuring staff were trained on the grievance process. The ADM stated she was not aware the grievance procedure was not being discussed in Resident Council. Interview with the SW on 12/12/2024 at 12:32 PM, the SW stated she reviewed grievances and assigned grievances to the appropriate department heads. The SW stated the facility had 72 hours to resolve grievances once they were submitted. The SW stated department heads addressed the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant. The resolution was documented on the grievance form and the completed form was submitted to the ADM for review. The SW stated completed grievance forms were kept in a notebook. The SW stated the grievance forms were kept in her office. The SW stated the residents did not have access to the grievance form . She stated there used to be a box on a wall in the facility, however, the box fell off the wall many months ago. The SW stated she assisted residents with completing grievance forms and she completed grievances forms once she received the Resident Council minutes. The SW stated there was no procedure for residents to submit Grievances anonymously , however, she understood the need to have a protocol for residents completing the Grievance form anonymously. Record review of the facility's Grievance policy on reflected the Grievance/complaint procedure should be posted on the resident bulletin board. Record review of the facility's Grievance Policy, last revised in 2024, reflected Our facility will assist Residents and their representatives, other interested family members, or advocates in filing grievances or complaints when such requests are made . Policy Interpretation and Implementation: 1. Any resident, family member, or representative may file a grievance or complaint. 2. Grievances and/or complaints may be submitted orally, in writing, or electronically and may be filed anonymously. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. All grievances, complaints, or recommendations stemming from resident or family concerning issues of residents' care in the facility will be considered. Actions will be responded to in writing. 4. Upon admission residents are provided with written information on how to file a grievance. A copy of our grievance/complaint procedure is posted in the facility. 5. The contact information for the individual with whom a grievance may be filed is provided to the resident and/or representative upon admission. 6. The ADM has delegated the responsibility of grievance investigation to the grievance officer. 7. The grievance officer will review and investigate the allegations and submit the written report of such findings to the ADM within 72 hours of receiving the grievance. 8. The grievance officer will coordinate actions with the appropriate state and federal agencies depending on the nature of the allegations. 9. The ADM and staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated. 10. The ADM will review the findings with grievance officer to determine what corrective actions need to be taken. 11. The resident or person filing the grievance on behalf of the resident, will be informed (verbally or in writing) of the findings of the investigation and actions will be taken to correct any identified problems. A written summary of the investigation will be provided to the resident and a copy will be filed in the business office. 12. If the grievance is filed anonymously the grievance officer will inform the resident that a grievance has been anonymously filed on his or her behalf and the steps that will be taken to investigate the grievance and report the findings. 13. The results of all grievances files investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 2 medication carts (Medication Cart 2 and Medication Cart 4) reviewed for medication storage . 1. The facility failed to keep Medication Cart 2 free of loose and unlabeled pills. 2. The facility failed to keep Medication Cart 4 free of loose and unlabeled pills. These failures could place residents at risk of harm or decline in health due to lack of medication labeling. Findings include: 1. During an observation on [DATE] at 1:25 PM, with LPN A, revealed one oval white loose pill found on the last bottom drawer of medication cart 2. LPN A and the DON verified medication was metoprolol (a blood pressure medication). During an interview with LPN A at 1:25 PM, she stated she has been trained to check the medication carts daily when taking over the cart. She stated she was trained to check for cleanliness, expired medication or items, and loose pills. She stated the potential negative outcome of having loose pills in the cart could be a medication error if someone were to accidently grab it . 2. During an observation on [DATE] at 1:39 PM, with LPN B, revealed one round orange pill was found on the last bottom drawer of medication cart 4. LPN B and the DON verified the loose pill was Bisacodyl (a laxative). During an interview with LPN B on [DATE] at 1:39 PM, she stated the night shift usually checked the carts at night and she would also check the cart when she took over. She stated they were trained to check for expired medication and cleanliness. She stated her last training was approximately one year ago upon hire. She stated the potential negative outcome of having loose pills in the cart could be giving the wrong medication to a resident . During an interview with the DON on [DATE] at 10:08AM, she stated the medication carts should be checked daily. She stated the medication carts should be checked for expiration dates, loose pills and restock items as needed. She stated the DON and ADON would check the carts at least once a week as well as the medication room. She stated they monitored compliance by doing a check after a nurse completed their check of the medication cart. She stated the potential negative outcomes of loose pills in the cart could be a missed resident medication, and a potential for medication error. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADM on [DATE] at 10:59AM, she stated the nurses were trained to check the medication carts daily when they came on shift. She stated compliance was monitored by the nursing administration. The ADM stated the potential negative outcome could be a medication error, or the medication being placed in the incorrect bottle. Record review of the facility's policy titled Storage of Medications:, last revised in [DATE], revealed, Policy Statement The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation . 2. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . .10. Resident medications are stored separately from each other to prevent the possibility of mixing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 41480 Based on observation, interview, and record review the facility failed to ensure each resident received and the facility provided food that was palatable, attractive, and at a safe and appetizing temperature for 1 of 3 food forms (puree) at 2 of 4 meals (12/12/24 noon meal and 12/11/24 dinner meal) reviewed for palatability. The facility failed to provide food that was palatable for 1 of 3 food forms served (regular, mechanical soft and puree) at 2 of 4 meals observed (12/10/24 lunch and 12/11/24 dinner) . These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings include: During an observation on 12/10/24 at 12:20 PM revealed 4 puree plates served to residents with chunky baked chicken and okra/tomatoes with large seeds. During an observation on 12/10/24 at 12:35 PM revealed a test tray with rotisserie chicken that had large chunks of meat that had to be chewed. The okra/tomato had whole okra seeds that had to be chewed. During an observation on 12/11/24 at 03:51 PM revealed [NAME] A prepared puree hamburger meat, cheese, and bread per the menu. A test tray revealed the hamburger meat, cheese and bread puree had chunks that had to be chewed. [NAME] A prepared puree Mexican cream corn, a test tray revealed the Mexican cream corn had corn skin that had to be chewed . During an interview on 12/11/24 at 04:10 PM with [NAME] A, she stated puree should be smooth, like baby food. She stated she was not able to make the corn smooth. She stated puree diet was made for residents who were unable to chew or swallow. She stated she had been trained on how to prepare puree meals. She stated the potential negative outcome could be the resident choking. During an interview on 12/13/24 at 09:43 AM with the DM, she stated she was responsible for training staff. She stated puree foods should be the consistency of apple sauce texture with no chunks. She stated residents were on puree diet because they had trouble swallowing. She stated cooks were trained to add more liquid if needed and spin food around with spoon and then look at food for chunks. She stated the potential negative outcome could be a resident could choke or aspirate on the food chunks. During an interview on 12/13/24 at 10:00 AM with the ADM, she stated the DM trained all staff on how to prepare puree diets. She stated puree should be pudding consistency. She stated residents were on a puree did because they could not chew food. She stated the potential negative outcome could be a resident choking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Texture Modifications, dated 2013, revealed the following documentation, Pureed Texture Description - the pureed texture is a mechanical modification of the Regular Diet or any therapeutic diet, designed for people with moderate to severe swallowing difficulty and a poor ability to protect their airway. This texture allows pureed food (pudding like consistency) that is smooth and easily stays together. Food should be avoided if they require chewing. Coarse and dry texture, raw fruits and vegetables, breads and nuts should also be avoided . Food Group - Vegetable Food Allowed - Vegetables should be soft, well cooked and pureed without lumps, husk or seeds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Residents #229) reviewed for infection control. CNA C and CNA D failed to utilized enhanced barrier precautions during foley care for Resident #229 on 12/11/2024. This failure could place residents at risk for infection and cross contamination. Findings include: Record review of Resident #229's, undated, face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #229 had a medication history of COPD (a condition caused by damage to the airways or other parts of the lung), fracture of the left femur, atrial fibrillation (abnormal heartbeat), and chronic kidney disease, end stage. Record review of Resident #229 admission MDS dated [DATE], Section C- Cognitive Patterns revealed a BIMS score of 13, which indicated Resident #229 was cognitively intact. Record review of Resident #229 physician orders revealed an order for Foley Catheter care every shift and as needed, dated 10/23/2024. Record review of Resident #229's care plan revealed the following intervention Enhanced Barrier precautions, last revised 12/04/2024. During an observation of foley care on 12/11/2024 at 3:00 PM, revealed Resident #229's door had an Enhanced barrier precaution sign that was visible from the hallway and prior to entering the room. CNA C and CNA D entered Resident #229's room to perform foley care. CNA C and CNA D failed to use a gown for foley care. During an interview with CNA C on 12/11/2024 at 3:18 PM, she stated she was trained on infection prevention, but she was an agency CNA and did not remember being trained at this facility. She stated enhanced barrier precautions were utilized for residents who had tubes or wounds. She stated the enhanced barrier precautions were used to prevent contamination and many other things. She stated the potential negative outcomes could be passing infection to another resident. She stated with Resident #229 she was supposed to wear the gown, but she felt they did everything too fast and they did not grab the gown. She stated she realized she forgot the gown but did not want to say anything because she was nervous. She stated the infection preventionist at the facility was the DON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Heal Th Care Cen	705 NE Georgia Avenue Sweetwater, TX 79556

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA D on 12/11/2024 at 3:39 PM, she stated she was trained on infection control and her last training was about three weeks. She stated anytime a resident had a foley catheter or feeding tube, they were to use gloves and gowns. She stated she realized she forgot to wear the gown when she entered the room. She stated the potential negative outcome of not utilizing all the PPE could be spreading infection. She stated she utilized PPE for residents who were on EBP, but she got nervous and forgot to grab the gown. She stated the DON was the infection preventionist. During an interview with the DON on 12/12/2024 at 10:03 AM, she stated she was the infection preventionist. She stated staff were trained monthly on infection control and anytime anything came up. She stated she was doing more EBP training. She stated the potential negative outcome of staff not utilizing proper PPE could be spreading infection. She sated she expected her staff to wear the correct PPE when they provided care, and that was why the signs were on the doors. She stated she monitored compliance by doing rounds and educating staff. She stated she educated agency staff to make sure they knew what was expected and that they were aware of the rules. She stated they made rounds to make sure the correct PPE was being utilized. During an interview with the ADM on 12/12/2024 at 10:58AM, she sated the DON was the infection preventions. She stated staff were trained on EBP at least every three months. She stated compliance was monitored by making rounds. She stated the potential negative outcome of not utilizing proper PPE could be spreading infection. She stated for EBP, the staff was to wear gowns and gloves when they provided care. Record review of the facility's policy titled Enhanced Barrier Precautions last revised on 4/1/2024, revealed, . EBP are indicated for residents with any of the following: . Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO (multi-drug resistant organism) . Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies . The facility will ensure PPE and alcohol-based hand rub are readily accessible to staff prior to entry to their room. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities .changing briefs or assisting with toileting- yes don gloves and gown.