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	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Healthcare Cente	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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to transmit completed discharge assessment that accurately reflected the residents' status for 1 of 23 sampled residents (Resident #83) whose records were reviewed, in that: Resident #83 discharge MDS was not transmitted within 14 days of the completed date. This failure could place residents at risk by not receiving the appropriate assessments.Based on interview and record review the facility failed to transmit completed discharge assessment that accurately reflected the residents' status for 1 of 23 sampled residents (Resident #83) whose records were reviewed, in that: Resident #83 discharge MDS was not transmitted within 14 days of the completed date. This failure could place residents at risk by not receiving the appropriate assessments. The findings include: Resident #83 Record review of Resident #83 admission Record dated 03/26/2026 revealed a [AGE] year-old male resident admitted to the facility on [DATE] and a discharge date of 12/31/2025 with admitting diagnoses of muscle weakness, nontraumatic subacute subdural hemorrhage (bleeding in the brain), seizures, and major depressive disorder (mental health condition that causes a persistently low or depressed mood and loss of interest in activities). Record review of Resident #83's electronic medical record MDS tab revealed a discharge Return Not Anticipated MDS dated [DATE] with a status of complete. The assessment history revealed the discharge MDS had not been submitted (no batch created). Record review of Resident #8's3 discharge MDS dated [DATE] revealed the following: Section A0310 Type of assessment: .F. Code 10 - Discharge assessment - return not anticipated .Section A2000 discharge date : [DATE] .Section Z0500 RN assessment Coordinator Verifying Assessment Completion:A. Signature: DON B. Date RN assessment Coordinator signed assessment as complete: 01-08-2026 During an interview with MDS Nurse A and MDS Nurse B on LVN D on 03/25/2026 at 03:49 a.m. MDS Nurse A stated Resident #83 was not traditional Medicare, he was managed care and MDS assessments were not transmitted to CMS. MDS Nurse B Stated Resident #83 discharged MDS should have been submitted to CMS. MDS Nurse B stated all discharge MDS' should be transmitted to CMS within 14 days of the completed MDS. MDS Nurse B stated it was missed by mistake. MDS Nurse A stated there was a box they must uncheck or once the MDS was completed it would not be transmitted to CMS. MDS Nurse A stated the box was checked and the discharge MDS for Resident #83 had not been transmitted to CMS. MDS Nurse A stated it had been corrected and would be transmitted today (3/25/2026). MDS Nurse A stated the discharge MDS was completed and the DON reviewed it for accuracy and signed it. MDS Nurse A stated once the DON signed, the MDS it was transmitted. MDS Nurse A stated they had been trained in completing MDS and timeframes. During an interview with the DON on 03/26/2026 at 09:40 a.m. she stated the purpose of the discharge MDS was to notify CMS of the status of the resident. She stated when a resident discharges an assessment was completed the day of discharge. She stated she reviews and signs the discharge MDS and the MDS nurses transmit to CMS. She stated she was not aware Resident #83 discharge MDS was not transmitted. She stated the MDS nurses had been trained on MDS assessments and transmission. She stated the potential negative outcome would be not notifying CMS of a resident's (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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status and the facility could continue to bill and receive payments from Medicare for a resident not in the facility. During an interview with the ADM on 03/26/2026 at 09:49 a.m. she stated the purpose of the discharge MDS was to inform CMS of the resident's status and stop billing. She stated the MDS nurses and DON were responsible for completing and transmitting the MDS to CMS. She stated they had training on MDS completion and time frames. She stated the discharge assessment should be transmitted within 14 days. She stated she was not aware Resident #83 discharge MDS had not been transmitted until today. She stated the potential negative outcome could affect the billing process. Record review of facility policy dated 06/02/2025, titled MDS Coding Policy revealed: affiliated facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident assessment, timely and accurately.The most current RAI manual may be found on the CMS.gov website. Review of the RAI manual dated October 2025 revealed: . 09. Discharge assessment - Return not anticipated (A0310F=10) .Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days) .

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pain management was provided to residents who required such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 23 residents (Resident #43) reviewed for pain management. The facility failed to ensure Resident #43 had effective pain management by failing to have their PRN pain medication available. This failure could place residents at risk for increased pain and decreased quality of life.Findings included: Record review of an undated face sheet revealed Resident #43 was a [AGE] year-old female with an initial admission date of 05/02/2025 and admission date of 02/23/2026 with the diagnoses vascular dementia, unspecified severity, without behavioral disturbance mood disturbance, and anxiety (cognitive decline caused by reduced blood flow to the brain, often following strokes or small vessel disease with a mental health condition), inflammatory polyneuropathy unspecified (autoimmune disorder where the immune system mistakenly attacks the nerves), chronic pain due to trauma (persistent pain lasting beyond 3-6 months that stems from physical injury or emotional/psychological trauma), essential (primary) hypertension (high blood pressure), rheumatoid arthritis, unspecified (a chronic inflammatory disorder that could affect more than just your joints. In some people, the condition could damage a wide variety of body systems, including the skin, eyes, lungs, heart, and blood vessels), unspecified osteoarthritis (lack of cartilage at the ends of the bones which causes joint pain, stiffness, and reduced mobility), pain in right shoulder, low back pain, muscle spasms of back (sudden involuntary painful contractions or tightening of the muscles), fibromyalgia (chronic long-term disorder characterized by widespread musculoskeletal pain), pain unspecified, localization-related focal partial symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus (a severe treatment-resistant form of epilepsy where seizures originate in a specific, localized area of the brain, causing conscious simple focal seizures that have progressed to dangerous, prolonged seizure activity), and fracture of first thoracic vertebra, initial encounter for closed fracture (a break or collapse of the bones in the upper or mid-back). Record review of Resident #43's Comprehensive MDS assessment dated [DATE] revealed she had a BIMS score of 15 which indicated Resident #43 was cognitively intact. In Section J - Health Conditions, the pain assessment revealed Resident #43 reflected pain almost constantly and that pain interfered with day-to-day activities frequently. Record review of Resident #43's undated care plan revealed: focus: The resident has chronic pain related to inflammatory polyneuropathy, right shoulder pain, lower back pain, osteoarthritis, muscle spasms, fracture of thoracic vertebra, fibromyalgia, rheumatoid arthritis. (Fentanyl patch, Lyrica, HCD 10 MG (hydrocodone 10 mg), Lidocaine patch, meloxicam), date initiated 08/27/25, revision on: 01/19/2026. Interventions: anticipate the resident's need for pain relief and respond immediately to any complaint of pain, monitor/record/report to the nurse resident complaints of pain or requests for pain treatment, observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decreased range of motion, withdrawal, or resistance to care. The resident prefers to have pain controlled by Fentanyl patch (a powerful synthetic opioid designed for pain management) every 2 hours - check for placement every shift. Hydrocodone PRN (an opioid and acetaminophen used to manage severe pain). Lidocaine patches (fast acting numbing agent) to the lower back. Lyrica (medication used to treat nerve pain) as instructed by the physician, Methocarbamol (muscle relaxant use to treat painful muscle spasms and stiffness) as instructed by the physician for muscle spasms. Meloxicam (nonsteroidal anti-inflammatory medication used to relieve pain) as instructed by the physician. Record review of Resident #43's physician's orders revealed active orders as of 03/26/26 for Hydrocodone/Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) (an opioid and acetaminophen used to manage severe pain) give 1 tablet by mouth every 6 hours as needed for breakthrough pain. Order date 03/09/2026. Start date 03/09/26. No end date indicated. Record review (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident #43's MAR, dated 03/01/2026 to 03/31/2026, revealed she was prescribed Hydrocodone/Acetaminophen 10-325 MG (1) tablet by mouth every 6 hours as needed for breakthrough pain with an order date of 03/09/2026. The MAR revealed Resident #43 received doses on 3/23/26 at 5:29 AM and 12:44 PM. Resident #43's MAR revealed the next dose was received on 3/24/26 at 11:36 AM. Record review of Resident #43's narcotic count sheet dated 02/16/2026 revealed the last Hydrocodone/Acetaminophen 10-325 MG (1) tablet was administered at 12:30 PM on 03/23/2026. The count was zero after the 12:30 PM dose was administered on 03/23/2026. Record review of Resident #43's narcotic count sheet was dated 03/25/2026 revealed a new prescription of Hydrocodone/Acetaminophen 10-325 MG was filled with a count of 56 pills. Record review of progress notes for Resident #43's dated 03/25/2026 at 8:28 AM, revealed a notation that a nurse called the physician's office and requested a prescription for Norco (a prescription medication combining hydrocodone (an opioid) and acetaminophen used to manage severe pain) to be sent to the pharmacy provider, and the physician's nurse replied the prescription would be sent to the physician and pharmacy provider today. During an interview on 03/24/2026 at 2:43 PM, Resident #43 stated she requested her prescription hydrocodone pain medication the other day at night because she was in pain and was told by the nurse that they could not get the code needed to access to the emergency medication kit because they could not get ahold of the pharmacy provider. She stated the nurse told her the hydrocodone was ordered previously but had not yet been delivered. She stated the facility told her they ran out of the hydrocodone that was kept in the medication cart which was why they had to get them from the backup emergency medication supply kit. During an interview on 03/26/2026 at 9:23 AM, Resident #43 stated after she reported pain, the nurse told her she called the pharmacy provider every hour, but they were not answering. She stated staff repositioned her with pillows a few times which helped alleviate some of the pain. She stated staff also rubbed her fentanyl patch that she was already wearing. She stated she was aware she could have taken over-the-counter acetaminophen but did not want to take it because then she would not have been able to take the prescription medication had they gotten access to the emergency medication kit. She stated staff also offered to send her to the hospital to get the medication if she wanted, but she declined. She stated staff updated her and checked on her every hour during that shift. She stated she slept off and on throughout the night. She stated she received the pain medication early the next morning. She stated this was the first time this had ever happened and that the facility did well managing her pain on a regular basis. She stated her regular prescription had since been filled and the issue was resolved. During an interview on 03/26/2026 at 11:36 AM, LVN E stated on Monday night (3/23/26) Resident #43 asked for pain medication one time during her shift. She stated she tried calling the pharmacy several times and kept getting a busy tone. She stated she checked on Resident #43 several times throughout the night and she was always asleep. She stated she could not recall the exact time the resident asked for pain medication, but she believed it to have occurred sometime after 10:00 PM. She stated she tried to call the pharmacy throughout the night. She stated she told Resident #43 about the issue of not being able to get ahold of the pharmacy and she replied that she was okay with it. She stated she passed on the issue of Resident #43's pain medication in report to the oncoming nurse before she left the facility. She stated Resident #43 only asked for the pain medication one time during her shift. She stated Resident #43 was not crying in pain or she would have called the physician immediately. She stated she should have called the DON but did not do it because the resident was able to sleep. She stated this had never happened to her before. She stated the reason she needed a code from the pharmacy to access the emergency medication kit was because there were no pain pills on the cart from Resident #43's regular prescription. She stated a potential negative outcome of not having resident's pain medications was that residents would have ongoing excruciating pain, which could cause high blood pressure, respiratory distress, and a high pulse rate. She stated she was the nurse on hall 4 and was responsible for ensuring residents on hall 4 received their medications that night. During an interview on 03/26/2026 at 12:39 PM, the DON (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she wanted pain for residents to be controlled and if not controlled, staff were to notify the physician to get medications to control the pain. She stated she was not aware staff could not get ahold of the pharmacy when Resident #43 requested pain medication. She stated staff were to notify her or the doctor if they could not get ahold of the pharmacy so they could attempt to find other options to help control pain. She stated there would not have been any other medication in the building that was stronger to give the resident than the medication that was available in the emergency medication kit. She stated Resident #43 had chronic pain but she told staff when she had severe pain. She stated she expected staff to notify her or the physician anytime staff could not get medications including PRN medications regardless of pain level of the resident so she could see if she could get the medication for the resident. She stated all staff knew they should call her as they had all been trained to notify her when medications were not available. She stated a potential negative outcome was that residents were without their life saving medications and having uncontrolled pain could have had adverse effects on the residents. She stated the emergency medication kit was the backup plan for when the medication was not available on the medication cart. She stated the prescription had since been filled. During an interview on 03/26/2026 at 12:58 PM, the ADM stated staff were to continue to call the pharmacy to get the code to access medications from the emergency medication kit when the medications were not available on the medication cart. She stated she expected staff to maintain communication with residents as to why the medication was not available. She stated she was not aware staff were not able to get ahold of the pharmacy on the night of 03/23/2026 for pain medications for Resident #43. She stated staff should have called the DON right away to see if there was another way to contact the pharmacy or get access to the medication by another route. She stated superiors could have helped the staff troubleshoot other options. She stated Resident #43 had a continuous fentanyl patch and often slept well. She stated staff should have notified the DON of not being able to get ahold of the pharmacy regardless of the resident's pain level. She stated she expected staff to call her or the DON for help in those situations. She stated the nurse was responsible for calling them and notifying them of the issue so they could have helped expedite the medication. She stated a potential negative outcome was that the resident was in pain and it was their right to not be in pain. The ADM stated another negative outcome was that they were not aware there was an issue with the pharmacy and had not addressed it and fixed the problem so to prevent it from happening again. Record review of facility policy titled, Pain Management Program Policy , reviewed 3/03/2026, revealed in part: The facility will ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices, related to pain management. 1. The facility will identify individuals who have pain or who are at risk for having pain. a. This includes reviewing known diagnoses and conditions that commonly cause pain; for example, degenerative joint disease, rheumatoid arthritis, osteoporosis (with or without vertebral compression fractures), diabetic neuropathy, oral or dental pathology, and post-stroke syndromes.b. This includes a review of any treatments that the resident currently is receiving for pain, including complementary and non-pharmacologic treatments.c. Caregiver will review when the resident is experiencing pain and identify circumstances when pain can be anticipated.d. Residents pain will evaluate and managed with residents' goals and preferences. Treatment/Management Strategies for the prevention and management of pain may include but are not limited to the following: - Assessing Pain: Recognizing the onset, presence, and duration of pain, and assessing the characteristics of the pain.- Addressing Underlying Causes: Treating the underlying causes of the pain, to the extent possible. Monitoring Pain Assessment/Interventions/Orders and Care Planning 1. Pain evaluation will be completed for each resident upon admission, readmission, quarterly, and with significant changes in condition. 2. If pain is identified, the following steps are initiated:- Create a pain care plan using standardized pain assessment tools.- Obtain orders for pharmaceutical and/or non-pharmaceutical interventions. 3. Nurses will assess residents' pain every shift using the appropriate pain evaluation tool and document the effectiveness of interventions.4. For (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents experiencing unmanaged pain, the Interdisciplinary Team will reassess and determine new causes, adjust care plans, and implement new interventions as needed. 5. Pain should be assessed before potentially painful procedures, such as wound care, and medication should be administered in advance to reduce discomfort.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 23 residents (Resident #43) reviewed for pharmacy services. The ADON failed to document pain medication given on 03/18/26 to Resident #43 on the residents' narcotics count sheet and the MAR. This failure could place residents at risk for medication error and drug diversion.Findings included: Record review of an undated face sheet revealed Resident #43 was a [AGE] year-old female with an initial admission date of 05/02/2025 and an admission date of 02/23/2026 with the diagnoses of vascular dementia, unspecified severity, without behavioral disturbance mood disturbance, and anxiety (cognitive decline caused by reduced blood flow to the brain, often following strokes or small vessel disease with a mental health condition), inflammatory polyneuropathy unspecified (autoimmune disorder where the immune system mistakenly attacks the nerves), chronic pain due to trauma (persistent pain lasting beyond 3-6 months that stems from physical injury or emotional/psychological trauma), essential (primary) hypertension (high blood pressure), rheumatoid arthritis, unspecified (a chronic inflammatory disorder that could affect more than just your joints. In some people, the condition could damage a wide variety of body systems, including the skin, eyes, lungs, heart, and blood vessels), unspecified osteoarthritis (lack of cartilage at the ends of the bones which causes joint pain, stiffness, and reduced mobility), pain in right shoulder, low back pain, muscle spasms of back (sudden involuntary painful contractions or tightening of the muscles), fibromyalgia (chronic long-term disordered characterized by widespread musculoskeletal pain), pain unspecified, localization-related focal partial symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus (a severe treatment-resistant form of epilepsy where seizures originate in a specific, localized area of the brain, causing conscious simple focal seizures that have progressed to dangerous, prolonged seizure activity), and fracture of first thoracic vertebra, initial encounter for closed fracture (a break or collapse of the bones in the upper or mid-back). Record review of Resident #43's Comprehensive MDS assessment dated [DATE] revealed she had a BIMS score of 15 which indicated resident #43 was cognitively intact. In Section J - Health Conditions, the pain assessment revealed Resident #43 reported pain almost constantly and that pain interfered with day-to-day activities frequently. Record review of Resident #43's physician's orders revealed active orders as of 03/26/26 for Hydrocodone/Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) (an opioid and acetaminophen used to manage severe pain) give 1 tablet by mouth every 6 hours as needed for breakthrough pain. Order date 03/09/2026. Start date 03/09/26. No end date indicated. Record review of Resident #43's narcotic count sheet dated 02/16/2026 for Hydrocodone/Acetaminophen 10-325 MG (1) tablet revealed a dose administered at 4:07 PM on 03/17/2026 with an amount of remaining pills as 15. The next entry line was blank. Then the next entry line revealed a dose was administered at 11:00 AM on 03/18/2026 with an amount of remaining pills as 13. Record review of Resident #43's MAR dated 03/01/2026 to 03/31/2026, revealed she was prescribed Hydrocodone/Acetaminophen 10-325 MG (1) tablet by mouth every 6 hours as needed for breakthrough pain with an order date of 03/09/2026. The MAR did not reveal Resident #43 received a dose on 3/18/26 at 12:30 AM. Record review of progress notes for Resident #43, date range 01/25/2026 to 03/26/26, did not reveal documentation by the ADON of when she administered Hydrocodone/Acetaminophen 10-325 MG to resident #43 on 03/18/2026 at 12:30 AM. During an interview on 03/26/2026 at 11:49 AM, the ADON stated she worked on 03/17/26 from 6:00 PM to 6:00 AM in hall 1 and was training two nurses. She stated Resident #43 lived on hall 4. She stated Resident #43 asked for pain medication (Hydrocodone/Acetaminophen 10-325 MG) and she gave it to her at (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:30 AM (03/18/2026) when the hall 4 nurse was on a break. She stated she forgot to sign the medication out on the narcotics count sheet and on the resident's MAR. She stated she got sidetracked because there was a feeding that needed to be done and she needed to show the two nurses how to do it. She stated that she was trained in the medication pass process which was that she was to pop the pill, sign it out on the narcotic count sheet, give it to the resident, and then document on the MAR if the resident refused or took the medication. She stated this was the system in place to ensure medications were accounted for. She stated she expected staff to pass medication according to the appropriate process of passing medications. She stated she was not aware she forgot to document the medication prior to surveyor notification today. She stated she was responsible for ensuring all medications were documented on the narcotics count sheets and the MAR. She stated a potential negative outcome of not following the medication pass process and not documenting medications given to residents was that the resident could be double dosed, which would be a medication error, or the resident could overdose on the medication. During an interview on 03/26/2026 at 12:39 PM, the DON stated staff must document all medications as they were given to residents. She stated staff must document in the narcotic count sheet as soon as they pop the medication, then document on the MAR indicating the resident took the medication, locked the computer screen but left the MAR open for possible changes, then attempted to administer the medication to the resident. The DON stated if the resident refused the medication, the staff was to correct the MAR to reflect the medication was refused. She stated she was not aware hydrocodone was given to resident #43 and was not documented on the resident's narcotic count sheet or the MAR. She stated the system they had to ensure all medications were accounted for was for the off-going and oncoming staff to count them on each shift. She stated she expected staff to notify her if medication counts were off. She stated she trained staff to follow and count medications from shift to shift and notify her of any medication discrepancies. She stated all nursing staff and herself were responsible for ensuring medications were being counted and documented correctly. She stated she expected staff to document medications when they were giving them and follow up to ensure they were effective. She stated a potential negative outcome of not following the medication pass process and not documenting medications was that staff could give medications again and residents could have had an adverse effect. During an interview on 03/26/2026 at 12:58 PM, the ADM stated staff were to sign out narcotics medication as soon as they administer it on the narcotic count sheet and on the resident's MAR. She stated she was not aware of the pain medication given to Resident #43 was not documented on the MAR or the narcotic count sheet until after surveyor inquiry today when it was brought to her attention. She stated the system to ensure medications were accounted for was for staff to document on the MAR and narcotic counts. She stated staff had been trained by senior floor staff, the ADON, and the DON on the medication administration process which includes documenting the medications on the narcotic count sheet and the MARs. She stated the nurse passing the medications and the DON were responsible for ensuring all medications given were documented. She stated she expected staff to follow all policies and procedures given to them. She stated a potential negative outcome was resident's care could be reduced, and it could affect resident's rights. She stated also that residents could get an additional dose before it was due, which could be very detrimental to the residents. Record review of facility policy titled, Medication Administration, reviewed and revised 03/05/2026, revealed in part: Documentation RequirementsAfter administration, the nurse documents:- Date and time administered- Dosage- Route- Injection site (if applicable)- Indication (if PRN)- Resident response, when required- Signature and credentials. Record review of facility policy titled, Controlled Substances , reviewed 6/24/2025, revealed in part: Policy Statement The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule 11-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). Policy Interpretation and Implementation Handling Controlled Substances1. Only authorized licensed nursing and/or pharmacy personnel have access to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Schedule IIcontrolled substances maintained on premises.3. Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record.4. If the count is correct, an individual resident controlled substance record is made for each resident who will be receiving a controlled substance. Do not enter more than one (1) prescription per page. This record contains:a. name of the resident;b. name and strength of the medication;c. quantity received;d. number on hand;e. name of the prescriber;f. prescription number;g. name of issuing pharmacy;h. date and time receivedi. time of administration;j. method of administration;k. signature of person receiving medication; andl. signature of nurse administering medication. Dispensing and Reconciling Controlled Substances1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/ follow-up.2. The system of reconciling the receipt, dispensing and disposition of controlled substancesincludes the following:a. Records of personnel access and usage;b. Medication administration records;c. Declining inventory records; andd. Destruction, waste and return to pharmacy records.12. Some controlled substances may be stored in the emergency medication supply. Reconciliation of controlled substances in the emergency supply is conducted at intervals established by the director of nursing services.

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	455509	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Hills Rehabilitation and Healthcare Cente	705 NE Georgia Avenue Sweetwater, TX 79556

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure in accordance with accepted professional standards and practices, medical records maintained on each resident were accurately documented for 1 of 23 residents (Resident #43) reviewed for accuracy of records. LVN E failed to document an incident when she could not get access to Resident #43's pain medication during the night shift on 03/23/2026 because she could not get ahold of the pharmacy provider in the electronic health record. These failures could affect residents whose records are maintained by the facility and could place the residents at risk for errors in care and treatment.Findings included: Record review of an undated face sheet revealed Resident #43 was a [AGE] year-old female with an initial admission date of 05/02/2025 and an admission date of 02/23/2026 with the diagnoses of vascular dementia, unspecified severity, without behavioral disturbance mood disturbance, and anxiety (cognitive decline caused by reduced blood flow to the brain, often following strokes or small vessel disease with a mental health condition), inflammatory polyneuropathy unspecified (autoimmune disorder where the immune system mistakenly attacks the nerves), chronic pain due to trauma (persistent pain lasting beyond 3-6 months that stems from physical injury or emotional/psychological trauma), essential (primary) hypertension (high blood pressure), rheumatoid arthritis, unspecified (a chronic inflammatory disorder that could affect more than just your joints. In some people, the condition could damage a wide variety of body systems, including the skin, eyes, lungs, heart, and blood vessels), unspecified osteoarthritis (lack of cartilage at the ends of the bones which causes joint pain, stiffness, and reduced mobility), pain in right shoulder, low back pain, muscle spasms of back (sudden involuntary painful contractions or tightening of the muscles), fibromyalgia (chronic long-term disordered characterized by widespread musculoskeletal pain), pain unspecified, localization-related focal partial symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus (a severe treatment-resistant form of epilepsy where seizures originate in a specific, localized area of the brain, causing conscious simple focal seizures that have progressed to dangerous, prolonged seizure activity), and fracture of first thoracic vertebra, initial encounter for closed fracture (a break or collapse of the bones in the upper or mid-back). Record review of Resident #43's Comprehensive MDS assessment dated [DATE] revealed she had a BIMS score of 15 which indicated resident #43 was cognitively intact. In Section J - Health Conditions, the pain assessment revealed Resident #43 reported pain almost constantly and that pain interfered with day-to-day activities frequently. Record review of Resident #43's physician's orders revealed active orders as of 03/26/26 for Hydrocodone/Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) (an opioid and acetaminophen used to manage severe pain) give 1 tablet by mouth every 6 hours as needed for breakthrough pain. Order date 03/09/2026. Start date 03/09/26. No end date indicated. Record review of Resident #43's MAR dated 03/01/2026 to 03/31/2026, revealed she was prescribed Hydrocodone/Acetaminophen 10-325 MG (1) tablet by mouth every 6 hours as needed for breakthrough pain with an order date of 03/09/2026. The MAR did not reveal documentation of when the medication was requested by Resident #43 and was not available after 10:00 PM on 3/23/26. Record review of progress notes for Resident #43, date range 01/25/2026 to 03/26/26, did not reveal documentation by LVN E in the electronic health record of when she could not get access to pain medication requested by Resident #43 because she could not get ahold of the pharmacy provider during the night shift on 03/23/2026. During an interview on 03/24/2026 at 2:43 PM, Resident #43 stated she requested her prescription hydrocodone pain medication the other day sometime at night because she was in pain and was told by the nurse that they could not get the code needed to access to the emergency medication kit because they could not get ahold of the pharmacy provider. She stated the nurse told her the hydrocodone was ordered previously but had not yet been delivered. She (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she did not know the nurse's name. She stated the facility told her they ran out of the hydrocodone that was kept in the medication cart which was why they had to get them from the backup emergency medication supply kit. During an interview on 03/26/2026 at 9:23 AM, Resident #43 stated after she reported pain, the nurse told her she called the pharmacy provider every hour, but they had not answered. She stated staff updated her and checked on her every hour during that shift. She stated she received the pain medication early the next morning. She stated it was the first time this had ever happened and that the facility did well managing her pain on a regular basis. She stated her regular prescription had since been filled and the issue was resolved. During an interview on 03/26/2026 at 11:36 AM, LVN E stated on Monday night (3/23/26) Resident #43 asked for pain medication one time during her shift. She stated she tried calling the pharmacy several times and kept getting a busy tone. She stated she kept trying to call pharmacy throughout the night. She stated she told Resident #43 about the issue of not being able to get ahold of the pharmacy and she replied that she was okay with it. She stated she did not notate this incident anywhere in the electronic health record like she was trained, but she should have. She stated she passed it on in report to the oncoming nurse before she left the facility. She stated she should have called the DON but did not do it because the resident was able to sleep. She stated this had never happened to her before. She stated the reason she needed a code from the pharmacy to access the emergency medication kit was because there were no pain pills on the cart from Resident #43's regular prescription, they had run out, but there was some available in the emergency medication kit. She stated she was the nurse in hall 4 and was responsible for documenting the residents' chart and ensuring residents in hall 4 received their medications that night. During an interview on 03/26/2026 at 12:39 PM, the DON stated she wanted pain for residents to be controlled and if not controlled, staff were to notify the physician to get medications to control the pain. She stated she was not aware staff could not get ahold of the pharmacy when Resident #43 requested pain medication. She stated staff was to notify her or the doctor if they could not get ahold of the pharmacy so they could attempt to find other options to help control pain. The DON stated this incident should have been documented in the resident's electronic health record. She stated a potential negative outcome was that residents were without their life saving medications and having uncontrolled pain could have adverse effects on the residents. During an interview on 03/26/2026 at 12:58 PM, the ADM stated staff were to continue to call the pharmacy to get the code to access medications from the emergency medication kit when the medications were not available on the medication cart. She stated she expected staff to maintain communication with residents as to why the medication was not available. She stated she was not aware staff were not able to get hold of the pharmacy on the night of 03/23/2026 for pain medications for Resident #43. She stated staff should have called the DON right away to see if there was another way to contact the pharmacy or get access to the medication by another route. She stated the nurse was responsible for calling them and notifying them of the issue so they could have helped expedite the medication. She stated the nurse was responsible for documenting the incident. She stated staff had been trained by senior floor staff, the ADON, and the DON on the medication administration process which includes documenting the medications on the narcotic count sheet and the MARs. She stated she expected staff to follow all policies and procedures given to them. The ADM stated a negative outcome was that they were not aware there was an issue with the pharmacy and had not addressed it and fixed the problem so to prevent it from happening again. She stated another potential negative outcome was resident's care could be reduced, and it could affect resident's rights. Record review of facility policy titled, Medication Administration , reviewed and revised 3/05/2026, revealed in part: PurposeTo ensure medications are prepared, administered, and documented safely, accurately, and in accordance with prescriber orders and accepted nursing standards of practice. General StandardsOnly individuals licensed or legally authorized in this state may prepare, administer, and document medications.The Director of Nursing or designee supervises and oversees all personnel involved in medication administration.4. Medications are administered according to prescriber orders and within ordered (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timeframes.6. Medication errors are documented, reported, and reviewed by the QAPI (Quality Assurance and Performance Improvement) committee to inform process changes and/or the need for additional staff training. During Medication PassMissed medications are followed up after completion of the medication pass.Refused, withheld, or rescheduled medications are documented appropriately on the MAR. Documentation RequirementsAfter administration, the nurse documents:- Date and time administered- Dosage- Route- Injection site (if applicable)- Indication (if PRN)- Resident response, when required- Signature and credentials. Record review of facility policy titled, Pain Management Program Policy , reviewed 3/03/2026, revealed in part: Monitoring Pain Assessment/Interventions/Orders and Care Planning1. Pain evaluation will be completed for each resident upon admission, readmission, quarterly, and with significant changes in condition. 2. If pain is identified, the following steps are initiated:- Create a pain care plan using standardized pain assessment tools.- Obtain orders for pharmaceutical and/or non-pharmaceutical interventions. 3. Nurses will assess residents' pain every shift using the appropriate pain evaluation tool and document the effectiveness of interventions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 2 of 3 residents (Resident #8 and Resident #52) reviewed for incontinence care.CNA C failed to utilize hand hygiene between glove changes when performing indwelling Foley catheter (a flexible tube inserted into the bladder to drain urine) care for Resident #8.CNA D failed to utilize hand hygiene between glove changes when performing incontinence care for Resident #52.These failures could place residents at risk for cross contamination and infection.The findings include:Resident #8Record review of Resident #8's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #8 had a medical history of cerebral palsy (disorders affecting movement, muscle tone, and posture caused by damage to the developing brain, usually before birth), chronic kidney disease (long-term, irreversible loss of kidney function), and neuromuscular dysfunction of bladder (nerve damage from diseases or injuries disrupts communication between the brain and bladder, leading to incontinence, urgency, or urinary retention).Record review of Resident #8's MDS dated [DATE] Section C- Cognitive patterns, revealed a BIMS score of 14 which indicated she was cognitively intact. Section H- Bowel and Bladder revealed Resident #8 had an indwelling catheter.Record review of Resident #8's physician ordered revealed Foley catheter care [every] shift and PRN with a start date of 10/5/2025.Record review of Resident #8's care plan revealed an intervention dated 3/13/2026 for The resident has (Indwelling) Catheter: DX: NEUROMUSCULAR DYSFUNCTION OF BLADDER.During a Foley catheter care observation on 3/24/2026 at 9:47am, revealed CNA C unfastened Resident #8's brief and cleaned the front genitalia (external sex organs). CNA C removed her dirty gloves and put on new gloves. CNA C did not utilize hand hygiene between glove changes. CNA C cleaned Resident #8's bottom and removed her dirty gloves. CNA C did not use hand hygiene prior to putting on clean gloves. CNA C removed Resident #8's dirty brief, removed her dirty gloves and applied new gloves. CNA C did not use hand hygiene between glove changes.Resident #52Record review of Resident #52's undated face sheet revealed an [AGE] year-old female admitted to the facility on [DATE]. Resident #52 had a medical history of chronic kidney disease with heart failure, muscle weakness and chronic gout (a painful, chronic form of inflammatory arthritis) due to renal (refers to the kidneys) impairment. Record review of Resident #52's quarterly MDS dated [DATE], Section C revealed a BIMS score of 15 which indicated Resident #52 was cognitively intact. Section H- Bowel and Bladder revealed Resident #52 was always incontinent of bladder.During an incontinence care observation on 3/24/2026 at 10:19am revealed CNA D unfastened Resident #52's brief and cleaned the front. CNA D turned Resident #52 onto her left side and cleaned her bottom. CNA D did not change her gloves or use hand hygiene before cleaning a different area Resident #56's body. CNA D changed her gloves after cleaning Resident #52's bottom and put on new gloves. CNA D did not use hand hygiene between glove changes. CNA D applied skin barrier cream to the resident's bottom with her right gloved hand. CNA D removed the glove to her right hand only and put on a new glove. CNA D did not use hand hygiene between the glove change.On 3/26/2025 attempted phone interview times for CNA C were conducted at 9:29AM, 9:44am and 11:01 AM. CNA C was not available for interview.During an interview on 3/26/26 at 9:31AM with CNA D, she stated she had been trained on infection control and hand hygiene. She stated her last training was approximately three months ago and every year she has skills checkoffs. She stated hand hygiene during incontinence was to be performed before starting the care, during the care, anytime gloves were removed, and after the care was completed. She stated she had been educated to use hand hygiene between glove changes and to have hand sanitizer on her at all times. She stated she usually did use hand sanitizer between glove changes but had not used hand hygiene during glove changes because she was nervous.During an (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 3/26/26 at 10:33 AM with the DON, she stated she was the infection preventionist. She stated infection control training was done quarterly and the training included hand hygiene and incontinence care. She stated compliance was monitored through infection trends and observations. She stated training on incontinence care included teaching staff to use hand hygiene between glove changes. She stated the potential negative outcome of not using hand hygiene between glove changes could be spreading infection. She stated she was not aware of staff not utilizing hand hygiene between glove changes. During an interview on 3/26/26 at 11:45AM with the ADM, she stated the DON was the infection preventionist. She stated infection control training was conducted quarterly. She stated in-services were also conducted regularly and as needed. She stated she expected nursing staff to follow policies and procedures when performing incontinence care, including utilizing hand hygiene between glove changes. She stated the potential negative outcome of not utilizing hand hygiene between glove changes could be spreading infections between residents or themselves. She stated she was not aware staff was not utilizing hand hygiene between glove changes.Record review of facility policy titled Handwashing-Hand Hygiene Policy and Procedures last revise 10/2020 revealed: 7. This facility considers hand hygiene the primary means to prevent the spread of infections.use an alcohol base hand rub contain at least 62% alcohol or alternatively soap.and water for the following situations.b. before and after direct contact with residents;.m. after removing gloves.9. The use of gloves does not replace hand washing/hand hygiene.