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	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Rehabilitation and Nursing LLC	1420 S 3rd Ave Sterling, CO 80751

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38503 Based on record review and interviews, the facility failed to ensure all residents were free from abuse, neglect, and exploitation, for one (#101) of two out of 29 sample residents. Specifically, the facility failed to ensure Resident #101 was not neglected by staff from 8/24/21 to 8/30/21 by providing the care and services the resident required to maintain the highest practicable well-being. The facility failed to implement timely treatment for Resident #101 who had a history of osteomyelitis (bone infection) to her right tibia/fibula (lower leg bone). Resident #101 readmitted to the facility following a below the knee amputation (BKA) to her right lower extremity (RLE) on 8/24/21. The facility failed to implement treatment to the surgical wound upon admission. The facility failed to notify the physician and obtain physician orders for treatment for six days. Due to the facility's failure, Resident #101's RLE became infected (had a foul odor) and the wound dehisced (burst open). Resident #101 was subsequently hospitalized on [DATE] to correct the facility's failure and was treated with a wound VAC (vacuum assisted wound closure), (see record review below). Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 6/26/22-6/29/22, resulting in the deficiency being cited as past noncompliance with a correction date of 9/7/21. I. Facility policy The Freedom from Abuse, Neglect, and Exploitation policy and procedure, dated 2017, was provided by the nursing home administrator (NHA) on 6/27/22 at 8:00 a.m. It documented, in pertinent part, It is the Facility's policy to provide for the safety and dignity of all its residents by implementing proper procedures for enforcing the residents' right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The facility shall develop and implement written policies and procedures that: (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 0600 Level of Harm - Actual harm Residents Affected - Few	-Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; -Establish policies and procedures to investigate any such allegations; -Include training on preventing abuse, neglect, and exploitation to all staff, service providers and volunteers, consistent with their expected roles. Training must include education on those activities which constitute abuse, neglect, misappropriation of property and exploitation; procedures for reporting relevant incidents; and dementia management and resident abuse prevention. Staff and volunteers shall receive training on preventing abuse, neglect, and exploitation upon hire, annually, and as needed. -Coordinates this policy with quality assurance and performance improvement (QAPI) program; and -Complies with section 1150B of the Social Security Act (requiring facilities to report any suspicion of crime for those in long term care facilities). In response to allegations of abuse, neglect, exploitation, or mistreatment, (name of facility) shall: -Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper time frame pursuant to this policy; -Have evidence that all alleged violations are thoroughly investigated; -Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress; and -Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 (five) working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. II. Resident status Resident #101, age less than 60, was admitted on [DATE] and discharged to the hospital on 3/17/22. According to the August 2021 computerized physician orders (CPO) diagnoses included osteomyelitis of right tibia and fibula (right lower extremity), dissection of artery of lower extremity, surgical amputation, and dehiscence of amputation stump. The 7/8/21 minimum data set (MDS) assessment revealed Resident #101 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required one-person limited assistance with most activities of daily living (ADLs) and did not reject care. Resident #101 had one venous/arterial ulcer with application of dressing for treatment. III. Facility investigation (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility investigation was provided by the NHA on 6/28/22 at 2:30 p.m. Review of the facility's investigation revealed on 9/1/21 the facility started an investigation related to Resident #101 being sent to the hospital on 8/30/21 for a wound dehiscence (see record review below). The facility documented they started an action plan as staff did not contact the physician to obtain treatment orders for Resident #101's right stump resulting in a wound dehiscence and infection. It was documented the only order that was obtained to treat Resident #101's surgical site was Iodosorb Gel 9%, an antimicrobial wound gel (see below). The facility interviewed nursing staff who cared for Resident #101 from 8/24/21 to 8/30/21 and revealed staff did not implement treatment orders. Staff were suspended pending the investigation and the DON later fired on 9/3/21. A full house audit was conducted of all residents to ensure treatment orders were in place, care plans were updated to reflect wound care and prevention for wounds. Education regarding skin management and change in condition was initiated on 9/1/21 with the individuals who cared for Resident #101. -However, the education did not include all nursing staff (see interviews below). Additionally, all staff were re-educated on abuse per facility policy above and the facility reported the incident to the State Survey Agency. The facility's investigation concluded that neglect was substantiated. IV. Record review 1. Hospital record The 8/24/21 hospital discharge record revealed Resident #101 had a right BKA on 8/6/21 and a BKA formalization (two-staged amputation) on 8/10/21. Wound care instructions read, Change dressing twice weekly or as needed. Place ABD (absorbent dressing) over the incision line, wrap in figure 8 (eight) pattern with kerlix gauze and re-apply sock and rigid removable dressing. 2. Progress note The 8/24/21 at 11:04 p.m. nursing note documented report was received from the previous shift that Resident #101 admitted to the facility at 1:00 p.m. Resident #101's skin assessment was completed with notation of multiple bruises, skin tears, open area to her left thigh, and incision to her right stump with a staple line incision (measured 4 centimeters) and incision line at the base of the stump which measured 23 cm (centimeters), the dressing was changed due to the wound having increased blood drainage. -However, there was no further documentation of treatment being provided to Resident #101's wound or assessment of the wound from 8/25/21 to 8/30/21 until she was sent to the hospital on 8/30/21 (see below). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Admission Data Collection There was no admission data collection on the day of admission 8/24/21. The 8/28/21 admission data collection documented the resident had a most recent admission on 8/28/21. It documented Resident #101 had a non-pressure vascular wound to the front of her left thigh and a non-pressure vascular wound to the front of her right lower leg. Resident #101 had pain in the wound. The acute care plan was blank. 4. Medication administration record (MAR) Review of the August 2021 MAR revealed an order dated 8/25/21 read, Iodosorb Gel 0.9% (antimicrobial prescription to treat wounds), apply to incision site topically one time a day every other day for infection prevention. It was documented the Iodosorb Gel 0.9% was applied on 8/25/21 and 8/29/21. On 8/27/21 it was not documented as being applied (see progress note below). 5. Treatment administration record (TAR) Review of the August 2021 TAR revealed no treatment orders for Resident #101's surgical right BKA site. 6. Care plan Review of Resident #101's care plan revealed there was no care plan initiated for her BKA until after the resident was re-hospitalized on [DATE] and returned to the facility on [DATE]. The care plan initiated 9/20/21 and revised on 9/23/21 revealed Resident #101 had an amputation to her RLE and she had a history of repeatedly picking at her skin and wound dressing. Interventions included to monitor the wound and document any signs and symptoms of infection, drainage, bleeding, impaired circulation, edema and pain. Change dressing as ordered, and encourage compliance with treatment. 7. Additional progress notes The 8/26/21 at 1:00 a.m. administration note documented Resident #101 complained of pain to the RLE stump, and pain was not relieved by positioning. The 8/27/21 at 10:52 a.m. administration note documented Resident #101 was picking at her skin and was not cooperative with care. The 8/27/21 at 3:26 p.m. administration note documented waiting at the pharmacy for Iodosorb Gel 0.9%. (continued on next page)

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