STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065174	A. BUILDING _____ B. WING _____	05/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STERLING LIVING CENTER	**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** - Minimal harm or potential for 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** Based on interviews and record review, the facility failed to ensure one (#1) of three out of 11 sampled residents were kept free from neglect. Specifically, the facility failed to ensure staff did not leave Resident #1 attached to the mechanical lift for an extended period of time. Findings include: I. Resident status Resident #1, age less than 65, was admitted [DATE]. According to the May 2020 computerized physician orders [REDACTED]. The 3/31/2020 minimum data set (MDS) assessment revealed no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. She required extensive assistance of two staff members for activities of daily living (ADLs) including transfers. II. Resident interview Resident #1 was interviewed on 5/12/2020 at 12:15 p.m. She said about two weeks ago she came into her room to have her brief changed and nurse aide (NA) #1 came in to assist her. She said NA #1 put the Hoyer lift sling under her and hooked her up to the lift and started lifting her up, when she stopped and told her that she needed to go get someone to help her, and left the room without giving the resident access to her call light. The resident said she waited about 10 minutes and her roommate put on her call light. She said NA #1 came back into the room, turned off the light and told her she was still trying to find assistance, and left the room again. She said after another 10 minutes, her roommate turned on the call light again. She said NA #1 returned, turned off the call light and left the room a third time, saying she was trying to find someone to help her. After another 10 minutes, she asked her roommate to turn on the call light again. She said a different certified nurse aide (CNA) came in to answer the light. She said she told the CNA she had been waiting for almost an hour for someone to get her out of the lift. She said the CNA stepped into the hallway and grabbed another staff member and they were able to transfer her onto the bed to be changed. She said she told the nurse on duty what happened and then told the nursing home administrator (NHA) a couple of days later. III. Record review A. Care plan The care plan, updated 5/8/2020, revealed the resident had an ADL self-care performance deficit and was totally dependent on two staff with a full body lift for all transfers. B. Nursing notes A 5/5/2020 nursing progress note revealed the resident stated a CNA left her suspended in the Hoyer for over an hour. It indicated the resident was assessed and found with no injuries and was assured a full investigation was being done. C. Facility investigation The 5/5/2020 suspected abuse investigation and summary was reviewed on 5/12/2020 and revealed the following: The incident took place on 5/3/2020 at approximately 5:00 p.m. to 5:30 p.m. It indicated the resident claimed NA #1 put her on the lift and left her suspended for over an hour. Staff and resident interviews were conducted as follows: -The interview with licensed practical nurse (LPN) #1, the nurse on duty during the incident, revealed the nurse denied the events occurred as stated and that the resident had made up information, as she makes up most of her stuff. She said the NA did hook up the resident to the lift but the resident was not suspended in the air at any time and only had to wait about five to ten minutes. The interview with NA #1 revealed she stated she hooked the resident up to the lift and started to lift the resident when she realized she needed another CNA to assist her, so she put the resident back down but left her attached in the sling and went to find someone to assist her. She admitted she went into the room twice and turned off the call light, letting the resident know she was still trying to find someone to assist her. She said she did not tell the nurse she needed assistance. The interview with NA #2 revealed she had come back from her lunch break and went to answer Resident #1's call light. She said when she entered the room, the resident was attached to the Hoyer, and so she stepped into the hallway and grabbed another CNA to assist her to transfer the resident to the bed. She said the resident told her she had been left in the lift for over an hour and she reported this to LPN #1. The conclusion was that NA #1 acted outside the scope of her work and left the resident attached to the Hoyer lift causing entrapment and the nurse failed to identify neglect. The NA received disciplinary action and the nurse was educated. IV. Staff interviews Certified medication aide #1 was interviewed on 5/12/2020 at 3:37 p.m. She said two staff members were needed whenever transferring a resident with a mechanical lift. She said it was not uncommon for one staff member to get the resident ready by putting the sling under them and attaching the sling to the machine, then a second staff member would come in and assist with the actual transfer. She said if she had difficulty finding a second person to assist her, she would not leave the resident attached to the machine. Nurse aide #2 was interviewed on 5/12/2020 at 4:50 p.m. She said she had answered Resident #1's call light on the day in question and found the resident hooked up to the Hoyer machine. She said the resident was very upset because the other NA had left her hooked up for a very long time. She said she did not recall the resident having any injuries related to being hooked up for so long. She said the resident should not have been hooked up to the machine until the staff was ready to transfer her. The nursing home administrator (NHA) was interviewed on 5/12/2020 at 5:07 p.m. She said the incident of the NA leaving the resident hooked up to the lift was neglect and the NA had been terminated. She said it was out the NA's scope of practice to use a lift unsupervised. She said staff should always have two staff members to transfer a resident with a mechanical lift.
F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide adequate nutritional and hydration care and services, consistent with the comprehensive assessment, for one (#2) of six residents reviewed of 11 sample residents. Specifically, the facility failed to: -Obtain weekly weights for Resident #2 after admission to monitor for weight loss; and -Monitor Resident #2's significant weight loss and initiate interventions to prevent further weight loss. The facility's failure to timely identify and respond to the resident's unplanned weight loss contributed to the resident's severe 14.6% weight loss within one month of admission. Finding include: I. Facility policy and procedure The Weight Management policy and procedure, last revised July 2017, provided by the medical records staff on 5/12/2020 at 6:53 p.m., included in pertinent part, Weigh all residents upon admission then weigh weekly for an additional three weeks, then monthly or as indicated. Staff should compare the current weight to the previous weight and a resident with a weight variance is reweighed within 48 hours. Weight variances include: a weight change of five pounds or a weight change of three pounds if weight is less than 100 pounds. Significant weight variances are defined as: -5% in one month -7.5% in three months -10% in six months Each resident with weight loss is reviewed weekly by the interdisciplinary team (IDT) at Risk Review Meetings. II. Resident status Resident #2, age 87, was admitted [DATE] and discharged [DATE]. According to the May 2020 computerized physician orders [REDACTED]. The 4/14/2020 minimum data set (MDS) assessment revealed the resident had moderately impaired cognitive function with a brief interview for mental status (BIMS) score of 11 out of 15. The resident required supervision with set up for eating and extensive assistance of one person for all other activities of daily living (ADLs). The MDS documented the resident had a poor appetite with a [DIAGNOSES REDACTED]. The resident's weight was 132 pounds. The resident had no known weight loss and was not receiving speech therapy. III. Family interview The resident's family member was interviewed on 5/8/2020. She said the resident was taken to a physician outside of the facility on 5/4/2020 and was found to have a

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

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.

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F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) significant weight loss of approximately 18 pounds in about a month. She said she took her family member out of the facility on 5/5/2020. IV. Record review The 4/5/2020 hospital progress note recorded the resident's weight at 59.7 kilograms (kg) or 131 pounds (lbs). The weights recorded by the facility were: -122 lbs on 4/11/2020 (a nine pound weight loss since being weighed at the hospital on [DATE]); -123 lbs on 4/16/2020; and -105 lbs on 5/5/2020, a 14.6% weight loss in two and a half weeks. No weights were obtained on week three and four after the resident was admitted . According to the 4/14/2020 situation, background, assessment, recommendation (SBAR) the resident's weight was 132 pounds, obtained 4/11/2020 (this weight was not recorded anywhere else in the resident's record). It indicated the resident needed a speech therapy evaluation. It revealed the resident was coughing, had difficulty swallowing, and trouble swallowing pills whole but did better with them crushed in applesauce. The 4/15/2020 speech therapy evaluation and plan of treatment revealed the resident was referred for services related to having difficulty taking medications. It indicated services were warranted to maximize nutrition and hydration with oral motor facilitation, postural control and to minimize the risk of weight loss with swallow analysis. The 4/16/2020 Nutrition Data Collection revealed the resident was on a regular diet with regular textures and thin liquids with his oral intake between 26%-50% and that he ate independently. It revealed he continued to receive a 4-ounce house supplement three times a day and there was no nutritional concern at that time. It indicated no change in weight (it did not address the weight difference between the hospital weight and the facility weight). It did not include laboratory information even though labs had been done on 4/14/2020. The 4/16/2020 Nutrition Registered Dietitian (RD) Assessment revealed the resident had increased calorie needs related to his low body mass index (BMI). The resident had inadequate intake related to his dementia as evidenced by his decreased sensation of thirst and loss of appetite. The rest of the assessment indicated to refer to the care plan. Review of the resident's meal intake on 5/12/2020 revealed from admission through 4/18/2020 the resident was documented to consume 2650% for the majority of meals. Beginning on 4/19/20 the meal intake record documented decreased meal intake of 0-25% for the majority of meals. The April 2020 CPO revealed no orders for interventions for weight loss including the house supplement mentioned in the Nutrition Data Collection above. The nutrition care plan, initiated 4/16/2020, revealed the resident was at a potential nutritional risk related to his diagnoses. Interventions included: -Provide and encourage estimated fluid needs for adequate hydration or physician order. -Offer preferred foods. -Assist with meals as needed. -Offer snacks as needed. -Monitor weights monthly or as indicated. -Monitor labs as available. -Encourage fluids with and between meals, including bedside water. -Remind of meal times and locations. -Registered dietitian (RD) to provide nutrition education as needed. -Refer to RD as needed. -Refer to a speech therapist as needed. -Encourage the resident to request large portions or second portions of foods enjoyed. -Encourage juice and milk with meals for added calories. -Provide house supplement per order. A 5/4/2020 nursing progress note written by the director of nursing (DON) revealed she had spoken with the resident's wife about her concerns over the resident's weight loss. It indicated she would contact the RD and see what interventions could be initiated for the weight loss. The 5/5/2020 speech therapy discharge summary revealed the concerns with difficulty swallowing medications were resolved but the speech therapist had concerns for intake and dehydration. V. Staff interviews The director of nursing (DON) was interviewed on 5/12/2020 at 10:50 a.m. She said the facility had recognized a problem with obtaining weights routinely in March and had initiated a performance improvement plan (PIP). She said the staff had missed doing Resident #1's weekly weights for four weeks and when the weight loss had been brought to her attention, she immediately implemented interventions, however the resident discharged home the next day. She said the weights were now being done by the restorative aide (RA) on Wednesdays and reviewed by the RD on Thursdays. If reweights needed to be done, the RA tried to get them done by Friday for the RD to review the following week. She said all residents were to be reviewed for weight loss weekly and interventions put into place. The surveyor attempted to interview the RD on 5/13/2020, however the RD did not respond.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections such as Coronavirus disease (COVID-19). Specifically, the facility failed to: -Ensure staff assisted residents with hand hygiene prior to being served meals; -Ensure staff performed proper hand hygiene in between tasks; -Ensure personal protective equipment was used appropriately when entering an isolation room; -Ensure residents vital signs were obtained and monitored routinely for COVID-19. Findings include: I. Professional references According to the COVID-19 Focused Survey for Nursing Homes, 3/20/2020, page 2, staff should assist residents to perform hand hygiene after toileting and before meals. According to the Centers for Medicare and Medicaid Services (CMS) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (Retrieved 5/22/2020), Healthcare professionals (HCP) should perform hand hygiene before and after all patient contact, contact with potentially infectious materials and before putting on and after removing PPE, including gloves. -HCP who enter the room of a patient with known or suspected COVID-19 should adhere to standard precautions and use of respirator, gown, gloves and eye protection. According to the Centers for Medicare and Medicaid Services (CMS) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html (Retrieved 5/22/2020), Healthcare personnel should adhere to Standard and Transmission-based Precautions when caring for patients with COVID-19 infection. -How to Put on PPE Gear . put on isolation gown. Tie all of the ties on the gown. According to the COVID-19 Preparation and Rapid Response: Checklist for Long-Term Care Facilities, 5/13/2020, Active monitoring of all residents should occur once daily to include temperature, heart rate, blood pressure, respiratory rate, pulse oximetry, changes in mental status, and any symptoms (cough, shortness of breath, difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory (smell) and taste disorder (s); consider also rhinorrhea, diarrhea, nausea or vomiting). II. Facility policies and procedures The Standard and Transmission Based policy, dated 2/2018, was provided by the NHA via email on 5/12/2020 at 7:32 p.m. The Hand Hygiene section read in pertinent part, Hand hygiene continues to be the primary means of preventing the transmission of infection. Staff were to complete hand hygiene, Before and after assisting a resident with meals. The policy read, Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections. It is necessary for staff to have access to proper hand washing facilities with available soap (regular or anti-microbial), warm water, and disposable towels and/or heat/air drying methods. Alcohol based hand rubs (ABHR) cannot be used in place of proper hand washing techniques in a food service setting. The Recommended techniques for washing hands with soap and water include wetting hands first with clean, running warm water, applying the amount of product recommended by the manufacturer to hands, and rubbing hands together vigorously for at least 15 seconds covering all surfaces of the hands and fingers; then rinsing hands with water and drying thoroughly with a disposable towel; and turning off the faucet on the hand sink with the disposable paper towel. Recommended techniques for performing hand hygiene with an ABHR include applying product to the palm of one hand and rubbing hands together, covering all surfaces of hands and fingers, until the hands are dry. In addition, gloves or the use of baby wipes are not a substitute for hand hygiene. The Transmission-based Precautions (TBP) section of the policy showed TBP was used for residents who were known to be, or suspected of being infected or colonized with infectious agents, including pathogens that require additional control measures to prevent transmission. It is essential both to communicate transmission-based precautions to all health care personnel, and for personnel to comply with requirements. Pertinent signage (i.e., isolation precautions) and verbal reporting between staff can enhance compliance with transmission-based precautions to help minimize the transmission of infections within the facility. It is important to use the standard approaches, as defined by the CDC for transmission-based precautions: airborne, contact, and droplet precautions. The category of transmission-based precaution determines the type of PPE to be used. Communication (e.g., verbal reports, signage) regarding the particular type of precaution to be utilized is important. When transmission-based precautions are in place, PPE should be readily available. Proper hand washing remains a key preventive measure, regardless of the type of transmission-based precaution employed. III. Hand hygiene observations A. The following observations were made on 5/8/2020: -From 11:46 a.m. until 12:04 p.m. staff, including certified nurse aides (CNAs) #5, #3, #4 and licensed practical nurse (LPN) #2, were observed serving lunch trays to residents in their rooms without assisting the residents with hand hygiene first. -At 11:52 a.m., CNA #2 came out of a room after delivering a meal tray without using hand hygiene. -At 11:59 a.m. a CNA #4 came out of a resident's room after delivering a meal tray, touched the door knob then walked over to the hydration cart, removed the lid off the milk and poured a glass of milk and gave it to a different resident without performing hand hygiene. -At 5:59 p.m. the director of nursing (DON) delivered meal trays to residents in their rooms

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) without assisting the residents with hand hygiene first. B. On 5/12/2020 at 11:44 a.m. a therapist delivered a resident's room tray without performing hand hygiene before or after the task, and did not assist the resident with hand hygiene prior to serving the meal. IV. PPE use observations The following observations were made on 5/12/2020: -At 10:24 a.m. housekeeper #1 was in a droplet precaution isolation room cleaning without having an isolation gown on and RN #2 did not have her isolation gown tied around her neck so it was falling forward off her shoulders as she was providing care to the resident in the isolation room. The RN was administering a nebulizer treatment with the door open. V. Vital signs record review May 2020 vital signs for three of three residents revealed full vital signs -- temperature, heart rate, blood pressure, respiratory rate, pulse oximetry, changes in mental status, and any respiratory symptoms (shortness of breath, cough, sputum production, sore throat, rhinorrhea) -- were not consistently completed two times a day per the Covid-19 Preparation and Rapid Response checklist for LTCFs, Part II Rapid Response. A. Resident #1 Vital signs from 4/30/2020 through 5/12/2020 showed the resident's respirations were not taken and recorded twice a day as required. Documentation revealed Resident #1's respirations were taken and recorded twice a day only on 5/2/2020 and 5/9/2020 and no respirations were documented on 5/11 or 5/12/2020. B. Resident #2 The May 2020 vital signs from 5/8/2020 through 5/12/2020 showed the resident's respirations and pulse were not taken and recorded twice a day as required. Resident #2's pulse and respirations were taken once daily and recorded three only times total in May 2020: 5/8, 5/10 and 5/11/2020. C. Resident #3 The May 2020 computerized physician orders [REDACTED]. An order dated 3/24/2020 read, Monitor for Respiratory Distress i/e Temp, Cough, SOB, O2 every shift. Documentation of Resident #3's May 2020 vital signs showed his BP, pulse and respirations were not consistently taken and documented as ordered. Record review showed no daily skilled nursing assessments or progress notes. The resident's blood pressure (BP) and pulse were each recorded one time in May 2020, twice in April 2020 and four times in March 2020. The facility failed to ensure physician orders [REDACTED]. Staff did not take and record the residents' full vital signs two times a day. VI. Staff interviews RN #1 was interviewed on 5/12/2020 at 6:45 p.m. She stated she had no problem with Resident #3 refusing care. She said she worked at night and did not take vitals. Nurse aide (NA) #2 was interviewed on 5/12/2020 at 6:46 p.m. She said vitals were not done all the time but were done whenever she had time. CNA #3 was interviewed on 5/12/2020 at 6:48 p.m. She stated vitals were done every shift at least two times a day. Certified medication aide (CMA) #1 was interviewed 5/12/2020 at 6:49 p.m. She said only oxygen saturations and temperatures were taken unless other vitals were needed. The nursing home administrator (NHA) and DON were interviewed on 5/12/2020 at 7:00 p.m. The DON said if the resident received [MEDICAL TREATMENT], a full set of vitals were done every shift (two times a day) and were rechecked if there were any out of range. Any resident who had daily appointments or left the building for appointments had a full set of vitals done every shift. She said otherwise they checked temperatures and oxygen saturation on every resident every shift and monitored them for anything wacky. The NHA stated vital signs were monitored twice a day for all residents unless they started to exhibit signs and symptoms then it was done more frequently.