STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215107	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Care Rockville Nursing	303 Adclare Road Rockville, MD 20850

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47758 Based on observations, interviews and record reviews, it was determined that the facility failed to provide a safe, comfortable, homelike environment. 1) This was found to be evident in 2 out of 2 shower rooms observed during the annual survey, and 2) An handrail was broken on the toilet. This was evident for 1 (Resident #58) out of 9 residents reviewed for environment. The findings include: 1) During an interview with Resident #97 on 1/13/25 at 12:25 PM, the surveyor was told to investigate the showers because they were dirty and broken. On 01/14/2025 at 10:15 AM, the surveyors observed that the second floor shower room contained 4 shower stalls, had stained ceiling tiles, a taped up vent in the ceiling with brown colored tape and tape hanging off the vent, and visible dark spots in the ceiling light covers. It appeared that 2 shower stalls had been recently used. The other 2 stalls were dry and equipment stored in the stalls. The third floor shower room stalls had one stall that appeared to be in use and 2 stalls with big perforations in the walls covered with taped on plastic, and a 4th stall that was filled with equipment. The Nursing Home Administrator (NHA) was informed of the concerns found by the surveyors on 1/16/25 at 8:38 AM. The NHA stated the 2nd floor shower stalls hadn't worked in years and the facility was working on repairing the showers. The Maintenance Director stated that an outside company was hired to work on the pipes. That when the work was completed and he and his staff would finish the repairs. When asked when the repairs would be completed, he stated in about a month. During an interview on 1/22/2025 at 8:15 AM, the Nursing Home Administrator stated we currently have 3 functioning showers but we are not having problems getting showers completed as scheduled. We plan to have two more up and running soon. 50385 (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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	215107	A. Building B. Wing	01/22/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 1/08/25 at 10:24 AM, an interview was conducted with Resident #58. They complained of a handrail attached to the toilet being broken for weeks. This surveyor observed two handrails attached to the toilet. The one on the right side was broken at the connecting piece of the toilet. Staff #4 was notified of the concern. Staff #4 stated this was the 1st time they were aware of the issue and stated that they would notify maintenance immediately. On 1/09/25 at 12:10 PM, an observation was done on Resident #58's room. The handrail on the toilet is visualized and was still broken. This surveyor notified the Administrator (Staff #1) of the broken handrail on the toilet. On 1/09/25 at 2:23 PM, an interview was conducted with the Maintenance Director (Staff #5). When asked how often the safety/support equipment is being checked, Staff #5 stated that monthly checks are conducted and equipment is being checked as damages are reported. When asked the average time it takes to address repairs, Staff #5 stated that repairs are prioritized by the severity of repairs and are attended to accordingly. When asked how they keep track of repairs, Staff #5 stated that they write concerns in their personal log as they come to them and write down the repair date once completed. When asked what was done to repair Resident #58's toilet handrails, Staff #5 stated that the hand rails were removed for safety and they had hand rails on the wall for the resident to use instead.

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	215107	A. Building B. Wing	01/22/2025

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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. 47758 Based on observation, record review, and interview, it was determined that the facility failed to prevent resident abuse. This was found to be evident for 2 (#134 & #85) out of 9 residents investigated for abuse during the recertification survey. The findings include: 1) Review of facility report MD00181452 on 1/13/25 at 7:54 AM, revealed that Registered Nurse #36 and Certified Medication Aide #21 observed Resident #135 approach and slap Resident #134, who was sitting in his/her wheelchair in the hall, on the left cheek on 3/19/2021 at 11:30 AM. The residents were separated and no injuries were observed or reported. Resident #135 was placed on 1:1 observation and sent to the Emergency Department for further assessment. The facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property was reviewed by the surveyor on 1/13/24 at 9:47 AM. The policy stated that physical abuse included slapping. On 1/13/25 at 9:44 AM, the DON was interviewed regarding the concern for resident-to-resident abuse. She stated that although she was not able to speak about the incident, she understood the concern. 50385 2) On 1/16/25 at 1:30 PM, the facility reported incident (FRI) #MD00197347 was reviewed. Resident #85 was diagnosed with Dementia and a Brief Interview of Mental Status (BIMS) of 0.0. BIMS is a cognitive screening tool used to assess a person's mental and cognitive health with scores ranging from 0 to 15, with higher scores indicating better cognitive function. According to the report, a staff member (Staff #26) witnessed Resident #85's family member pulling the residents hair and tapping their head. This incident was witnessed in hallway on the second floor, outside the resident lounge during lunch time, around 2:30 PM. The resident's family member stated they did not mean any malintent but was only trying to get the resident up to eat their food. The resident is unable to recall incident per report. The family member was placed on 1:1 visitor observation and a Behavioral contract was presented to the resident's family member. On 1/16/25 at 2:00 PM, an interview was conducted with the corporate nurse (Staff #27). When asked if there was any supporting documentation for this investigation, Staff #27 stated they cannot provide any additional documentation but could explain this incident in depth. When asked what happened in this investigation, Staff #27 stated that the regional corporate team takes charge in incidents/allegations of visitor to resident abuse. we went over with behavioral contract with our conditions which the family member was not happy about. They eventually understood the purpose of the contract and our conditions for his visits.

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	215107	A. Building B. Wing	01/22/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44440 Based on medical record review, internal report review and interview with resident and staff, it was determined the facility staff failed to report an allegation of abuse and an injury of unknown origin to the regulator agencies and Office of Health Care Quality (OHCQ). This was found evident in 2 (Resident #1 and #29) out of 10 residents reviewed for abuse and injuries of unknown origin. The findings include: 1a) On 1/8/25 at 8:49 AM, the surveyor interviewed Resident #1. During the interview Resident #1 recounted an alleged abuse that occurred. Resident #1 was not able to remember the exact date or recall what the person looked like but reported that it happened in the middle of the night and that he/she woke up with someone holding his/her nose closed. Resident #1 stated that he/she felt that the person was trying to kill them. On 1/10/25 at 9:16 AM, the surveyor reviewed Resident #1's medical record. The review revealed that on 12/12/23 a Palliative Care Physician Staff #39 evaluated Resident #1 and wrote a progress note that stated, Resident #1 noted with delusions. He/she feels someone was holding his/her nose in the night and someone stole his/her shoes. The note further stated that the shoes were on the resident and that the Resident #1 agreed the recent decrease in his/her medication may be contributing to the feeling. On 1/14/25 at 3:32 PM, the surveyor requested the investigation into the allegation of abuse from Resident #1 in 2023 from the Director of Nursing (DON). The DON stated she was unaware of any abuse and would look into the situation. On 1/14/25 at 3:52 PM, the surveyor conducted a follow-up interview with the DON. The DON confirmed that she would be starting an investigation into the allegation. 1b) On 1/16/25 at 7:39 AM, the surveyor reviewed Resident #29's medical record. The record revealed that on 9/3/23 Resident # 29's had x-rays done to the right arm to rule out a fracture after it was noted Resident #29 was having discomfort. No fracture was found. On 9/6/23 a result of a shoulder x-ray revealed Resident #29 had a right shoulder dislocation. Resident #29 was sent to the hospital for treatment. On 1/16/25 at 10:16 AM, the surveyor reviewed an investigation into the injury of unknown origin. The report found that no one witnessed a fall or incident to cause the dislocation. The previous Director or Nursing Staff #41 documented the Resident #29 was noted in wheelchair with arms on flat section of armrest. No other observations could rule reason for dislocation. On 1/27/2025 at 11:33 AM, the surveyor conducted a phone interview with the Director of Nursing (DON). During the interview the DON confirmed that the investigation into the injury of unknown origin was done internally. The surveyor reviewed the concern that facility failed to report and submit the investigation of this incident to the Office of Health Care Quality (OHCQ).

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	215107	A. Building B. Wing	01/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 44440 Based on review of the facility's investigation file and interview it was determined that the facility failed to maintain evidence that an injury of unknown origin was thoroughly investigated. This was found evident in 1 (Resident #32) out of 9 residents reviewed for abuse. The findings include: On 1/21/25 at 8:04 AM, the surveyor reviewed the investigation file regarding the investigation into the injury of unknown origin for Resident #32. The investigation listed all of the steps taken to investigate the injury and are as follows: 1. Head to toe assessment of the resident was completed and the Resident was sent for treatment and family updated 2. Residents in the hall were interviewed and any incapable residents had a head-to-toe assessment done 3. Director of Nursing was notified 4. Ombudsman notified 5. Interviews were conducted for any staff member on the hall at the time of the event 6. Police were notified 7. Self-report filed On review of the file no resident interviews or skin checks were in the investigation file. Statements from staff were provided, however, the statement from GNA #40, the staff that identified the injury, was not in the file. On 1/21/25 at 1:11 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the concern that the facility reported that they performed skin checks and interviews with residents from Resident #32's hallway, however they were not part of the investigation. The DON stated skin checks were done and she had the sheets to provide, however no interviews from capable residents were completed. On 1/22/25 at 11:10 AM the surveyor conducted a follow up interview with the DON. During the interview the DON stated that the statement was taken from GNA #40 however it was not in the investigation file but found in the concern forms documentation. The surveyor relayed the concern that the facility reported they did all the steps for a thorough investigation, however interviews from other residents were not done and two components of the investigation were not part of the investigation file.

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	215107	A. Building B. Wing	01/22/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44440 Based on interviews, and record review, it was determined that the facility failed to review and revise a resident's care plan after a resident's situation changed. This was found evident of 1 (Resident #28) out of 3 Residents reviewed for care planning during the survey. The findings include: On 1/13/25 at 10:59 AM, the surveyor conducted an interview with Resident #29's family member. During the interview Resident #29's family member was concerned that it was not communicated that his/her parent was hard of hearing. When asked if Resident #29 had hearing aids, the family member stated that Resident #29 had hearing aids at one time but would constantly take them out and they had asked the facility to stop using them so they would not be lost. On 1/16/25 at 10:53 AM, the surveyor reviewed Resident #29's medical record. The review revealed that Resident #29 had a care plan that stated Resident #29 had a hearing deficit. The care plan was revised on 3/9/21. In the interventions it stated, apply bilateral (both sides) hearing aids in the morning and out in the evening. On further review a treatment log for January 2025 had a place to document the left and the right hearing aid placement in the morning and removal in the evening. All days in January up to the 15th were documented as completed. On 1/17/25 at 9:44 AM, the surveyor interviewed the 2nd floor Unit Manager #6. UM#5 stated he would update a care plan if a Resident's Responsible Party (RP) requested a change in the plan of care. He further stated he was unsure if Resident #29 currently was using hearing aids but was aware that he/she wasn't using them as frequently anymore. On 1/17/25 at 12:26 PM, the surveyor reviewed the concern with the Director of Nursing (DON) that Resident #29 hearing care plan was not revised nor the treatment sheet to reflect the change that Resident #29 was not utilizing hearing aids anymore. The DON confirmed both areas needed to be updated to reflect the residents' care.

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	215107	A. Building B. Wing	01/22/2025

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on review of medical records, review of correspondences and interviews, it was determined that the facility failed to confirm and implement post-discharge care for residents requiring home health services. This was found evident in 2 (Resident #81 & #132) out of 3 residents reviewed for discharge planning. The findings include: 1) On 1/21/25 at 9:35 AM, the surveyor reviewed Resident #81's medical record. The review revealed that Resident #81 was admitted to the facility in September of 2021 with a past medical history that included, but not limited to, aftercare following joint replacement surgery, muscle weakness, abnormal gait and osteoarthritis (a chronic disease that breaks down cartilage and bone in the joints). On further review Physical Therapy (PT) worked with resident on 12/22/21 with therapeutic activities, therapeutic exercise and gait (walking) training. The therapist documented that therapy was indicated to help improve transfers, to address gait deviations, reduce assistance from caregivers, to improve time out of bed, and to reduce falls. The therapy noted that Resident #81 used both a rolling walker and wheelchair during therapy. On further review the surveyor noted the discharge instructions document dated 12/21/21 that indicated Resident #81 required in home care or services. Listed as services being provided were, Nurse, Aide, Physical Therapy (PT), and Occupational Therapy (OT). The documentation named the home care agency, however, no contact name or number was provided on the discharge instructions in the dedicated areas. The discharge instructions were signed by facility staff on 12/23/21. On 1/21/25 at 12 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor asked the DON for documentation showing the facility set up home care services for Resident #81 on discharge. On 1/21/25 at 2:28 PM, the surveyor conducted a follow up interview with the DON. During the interview the DON stated she reached out to the home health care agency and the DON provided their Client Coordination Note Report. The first page dated 12/23/21 was titled, Non-Admit Details. The note stated, no skilled nursing at this time. The next page of notes dated 1/5/22, titled, Clinical comment- intake. The notes state the following documents have been requested. History and Physical was checked off as received. Facility discharge summary, surgical notes, physical office notes including diagnosis list, current medication list from facility/physician, were all unchecked indicating the home health agency did not receive these documents. The next date on the Client Coordination Note Report was 1/6/22. The home agency's PT went to do a home visit and documented that the visit was missed by Resident #81 related to Resident #81 having a medical appointment. The home agency PT documents that Resident #81 was looking into another home care agency. The first visit from the home care agency was 13 days after Resident #81 was discharged from the facility. The surveyor relayed the concern that the facility discharged a resident without establishing an initial appointment within the first few days of being discharged after the facility indicated home health care was needed on discharge. 50385 (continued on next page)

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	215107	A. Building B. Wing	01/22/2025

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 1/17/25 at 8:30 AM, Complaint #MD00171169 was reviewed. The complaint states that Resident #132 was discharged on [DATE] and a home health nurse did not show up to provide care until 8/26/21. On 1/17/25 at 8:45 AM, a review of Resident#132's progress notes. On a discharge follow-up note from Social Services on 8/25/21 at 3:51 PM states, Resident was discharge to home on 08/18/2021 with friends assistance. Resident was referred to Community home health of MD for Home health services, however during the call with community home health it was discovered resident did not have a primarily care doctor in the community. [Social Services], followed with resident's friend no answer left a message expressing for resident to be seen by the [Nurse Practitioner so services can began. Resident's friend followed back up with [Social Services] on Monday 08/23/2021 [Social Services] informed [them] about the issue [they] stated that [they] reached out the PCP in the facility and he's willing to follow resident in the community. [Social Services], provided Community home health with the number of the [Primary Care Provider] to follow resident. Next day Community home health of Maryland called and said she's can't take on the case because there request was 35 hours and that cannot be done with the company. [Social Services], reached back out to resident's friend informing [them] that community home health could not provide the hours [they have] requested and another referral was sent out to Home Call. [Social Services] followed up with home call on 08/25/2021 they have reached out to resident's friend and a nurse will be out to see resident on 08/26/2021. Resident remains stable no distress noted. According to resident records, Resident #132 was discharged from the facility on 8/18/2021. On 1/17/25 at 10:45 AM, an interview was conducted with Staff #28. When asked what is required prior to discharging when a resident is going home with Home Health Agency (HHA), Staff #28 stated, We send out a referral to the HHA via email or fax. Once that is done we wait for a response to see if the services are accepted by HHA and the date of the start of services. This information is then relayed to the Resident Representative and Resident. When asked if it is their practice to require to know if services are accepted by the HHA prior to the discharge, Staff #28 stated Correct.

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	215107	A. Building B. Wing	01/22/2025

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 44440 Based on interviews and record review it was determined that the facility physician failed to acknowledge review of laboratory (lab) results of a resident. This was found to be evident in 1 (Resident #81) out of 2 residents reviewed for lab and radiology services. The findings include: On 1/21/25 at 9:35 AM, the surveyor reviewed Resident #81's medical record. The review revealed that Resident #81 was admitted to the facility in September of 2021 with a past medical history that included, but not limited to, elevated white blood cell count (indicating infection), over active bladder, pyelonephritis (inflammation or infection in the kidney) and Urinary Tract Infections (UTIs) and Hydronephrosis (swelling of the kidneys due to urine build up). On further review of Resident #81's medical records the surveyor noted that on 10/28/21 a urinalysis (UA) was obtained and a culture and sensitivity (C&S) was completed related to an order placed by the provider on 10/2721 and again on 10/28/21. Both of these laboratory tests are ordered to assess the health of the urinary tract. A UA is a test that analyzes the chemical composition of urine, and a C&S is completed only if bacteria is suspected from the UA. The C&S urine sample is completed in order to grow and identify the cause of infection and give treatment options for the infection. Resident #81's C&S resulted on 11/2/21 with results of 10,000-49,00 CFU/ml of the bacteria Escherichia coli (E coli). A paper copy of these results had an initial to indicate they were reviewed. The laboratory test was done again on 11/2/21 and the C&S results were reported on 11/6/21 with a note that indicated the lab was abnormal with greater than 100,000 CFU/ml of the bacteria of the same bacteria E coli. Resident #81 was prescribed an antibiotic by the provider to treat the infection on 11/4/21. Additionally Resident #81 had a UA obtained on 11/22/21 that was sent for a C&S and resulted on 11/26/21 at 1:27 AM. The results indicated the lab was abnormal and again resulting with greater than 100,000 CFU/ml of the bacteria but this time the bacteria was Pseudomonas Aeruginosa. However, there was no treatment ordered or an initial on the printed lab results. The surveyor reviewed the progress notes written by Resident #81's providers following the C&S results. On 11/26/21 Nurse Practitioner NP #33 wrote a follow-up progress note and that the primary care provider was working on a Urology (medical specialty that focuses on the urinary system and reproductive organs) consult. NP #33 documented that Resident #81 had no abdominal pain, no flank pain, no fever or chills, or nausea or vomiting. In the assessment and plan section of the note NP #33 wrote, labs, previous imaging, old records and therapy notes were reviewed in detail. She further writes, blood noted in urine, ultrasound sonography shows right renal cyst and urology will be consulted by primary provider. No where in the note indicated the results of the abnormal lab were reviewed or rational for non treatment. (continued on next page)

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	215107	A. Building B. Wing	01/22/2025

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Sterling Care Rockville Nursing	303 Adclare Road Rockville, MD 20850

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Next Resident #81's Primary Care Provider MD#34 wrote a progress note following a visit on 11/29/21. MD #34 wrote that the Resident #81 was seen and examined per nursing's request related to hematuria (blood in the urine). MD #34 further stated that the results of the ultrasound showed hydronephrosis and that a foley catheter was placed with continued hematuria. The repeated ultrasound showed a kidney stone and for the foley catheter to be flushed and monitored closely. MD #34 indicated that a urologist appointment was scheduled for Resident #81, and that lab and nursing documentation was reviewed. Further in the note, MD#34 stated Resident denies urinary urgency, frequency, dysuria, nocturia or difficulty voiding, however Resident #81 had a foley in place at this time. There was no mention or indication that the abnormal S&C was reviewed and that non treatment was indicated. On 1/22/25 at 12:35 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview, the surveyor asked the DON for the rationale as to why there was no treatment from the C&S that resulted on 11/26/21 when similar C&S was treated from the C&S that resulted on 11/2/21. The DON stated she would look into the concern and was aware that the Medical Director had conducted a review of Resident #81's medical record and would provide the report. Next the surveyor reviewed the report. The Medical Director wrote in regards to the urine culture that resulted on 11/26 that treatment would be out of caution, but not necessary per Center for Disease Criteria. There was no date on the review to indicate when the review was made. On 1/22/25 at 1:42 PM, the surveyor conducted a follow-up interview with the DON along with the Regional Clinical Nurse Staff #27. During the interview, Staff #27 stated the review by the Medical Director was conducted on 11/5/24 related to a medical records release. The surveyor relayed the concern that there was no documentation at the time that indicated the rationale for non-treatment or acknowledgement of abnormal laboratory results. The surveyor asked how lab results were validated as reviewed. The DON stated that electronically labs are marked as reviewed in the electronic health record or if the results are on paper that they would be initialed. When asked why the culture results on 11/2/21 were initialed but the results on 11/26/21 were not. The DON stated she had to print the lab results because the lab results were not in the paper record. The surveyor reviewed the concern that there was no documentation in the medical record to confirm the provider reviewed and/or acknowledged the abnormal labs and that there was no rationale for non treatment of the abnormal labs that resulted on 11/26/21.

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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. 44440 Based on review of the medical record, and interview, it was determined that the facility failed to provide a resident with routine medications as ordered. This was evident of 2 (Resident #82 & #99) out of 8 residents reviewed for medications. The findings include: 1) On 1/22/25 at 8:32 AM, the surveyor reviewed Resident #82's medical record. The review revealed that Resident #82 had a past medical history of diabetes mellitus type 2. Next the surveyor reviewed the May 2022 Medication Administration Record (MAR) for Resident #82. The review revealed that the medication Sitagliptin Phosphate, a medication indicated for Diabetes Mellitus, was marked as see progress notes on 5/4/22, 5/8/22 and 5/9/22. On 5/4/22 the progress notes stated, reordered from pharmacy, on 5/8/22 and 5/9/22 the notes stated, awaiting delivery from pharmacy. On 1/22/25 at 12:18 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor asked the DON why on three occasions, within a week, Resident #82's mediation not available from pharmacy. The DON stated she would look to see if an alternative medication was given and if the physician was aware and okay with the missing doses. On 1/22/25 at 12:35 PM, the surveyor conducted a follow-up interview with DON. The DON stated she was unaware of the reason and would reach out to the pharmacy to find out the reason. At the time of exit no additional documents were provided to explain why Resident #82's medications were not available. 50385 2) On 1/17/25 at 8:16 AM, a review of complaint #MD00170557 was conducted. The complainant stated that many residents' medications have not been administered specifically for Resident #99. On 1/17/25 at 9:30 AM, a review of Resident #99's progress notes was conducted. A care plan note from 8/10/21 stated, Resident missed 3 doses of Keppra [an anticonvulsant] and Latanoprost [eye drops to treat glaucoma and ocular hypertension] due to pending pharmacy delivery. Pharmacy was notified medications has been delivered. No seizure activities noted or any changes noted to resident. MD [Medical Doctor] and RR [Resident Representative] made aware On 1/17/25 at 9:45 AM, an interview was conducted with the Director of Nursing (Staff #2). When asked if there was an incident report regarding the missed doses of Keppra and Latanoprost, Staff #2 stated that she would check facility records. At 11:15 AM, Staff provided this surveyor with an incident report that included 2 nurses who did not administer the Keppra and Latanoprost over 2 shifts. Staff at the time received education on how to order medication from pharmacy if not available in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215107	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Care Rockville Nursing	303 Adclare Road Rockville, MD 20850

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44440 Based on observations and interviews it was determined that the facility failed to provide a safe, functional sanitary environment for a resident. This was found in 1 of 18 resident rooms reviewed in the initial sample. The findings include: On 1/8/25 at 8:37 AM, the surveyor conducted an interview with Resident #1. During the interview Resident #1 stated that the floors were not cleaned regularly in the back corner of his/her room due to a fall mat that ran alongside the bed. The surveyor observed debris on the floor at the back wall at the end of the fall mat. On further observation the surveyor observed a dark substance noted on the privacy curtain that appeared to have been left by finger impression. Also noted was the ceiling tile removed from above the unoccupied bed in the room, chair rail falling down from behind Resident #1's bed, the edge of the foot board sticking out, the top drawer to Resident #1's bedside night stand falling out when pulled out and a brown staining along the side of Resident #1's toilet. On 1/9/25 at approximately 12:30 PM, the surveyor observed the same conditions in Resident #1's room. On 1/9/25 at 12:44 PM, the surveyor conducted an interview with Licensed Practical Nurse (LPN) #4 and she confirmed the rooms were cleaned earlier in the morning. The surveyor showed LPN #4 the concerns noted in Resident #1's room. She stated she would address the issues. On 1/10/25 at 9:38 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA stated that the facility was working on fixing the identified concerns.