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	01/14/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interview it was determined that facility staff failed to treat each resident in a dignified manner by failing to place a urinary catheter drainage bag in a dignity bag. This was evident for 2 (#14, #15) of 5 residents reviewed for urinary catheters during a complaint survey.The findings include:1) On 1/13/26 at 12:25 PM observation was made of Resident #14 lying in bed. Resident # 14's foley catheter drainage bag was hanging off the side of the bed frame on the left side of the bed. A foley catheter is a flexible tub placed in the body which is used to empty the bladder and collect urine in a drainage bag. The resident's drainage bag was not placed in a privacy/dignity bag to enhance privacy to the resident.Review of Resident #14's January 2026 Treatment Administration Record (TAR) documented the physician's order, catheter care: ensure dignity foley bag is in use every shift. The order was written on 1/11/26.On 1/13/26 at 12:35 PM RN #15 was informed of the finding.2) On 1/13/26 at 12:27 PM observation was made of Resident #15 lying in bed. Resident #15 had a foley catheter drainage bag hanging off the side of the bed. The drainage bag was not in a dignity bag.On 1/13/26 at 12:35 PM RN #15 was informed of the finding and said it should have been in a privacy bag.

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility staff failed to honor the wishes of a resident's representative (Resident #6). This was evident for 1 of 19 residents reviewed during a complaint survey.The findings include: Review of a complaint on 1/12/26 from Resident #6's representative (RP) sent to OHCQ (Office of Health Care Quality) on 10/29/25 revealed the RP stated he/she received an email from the facility on 10/28/25 stating they would not discharge the Resident on 10/30/25 unless he/she sent a signed AMA (Against Medical Advice) form to the facility. Review of Resident #6's medical record on 1/12/26 revealed the Resident was admitted to the facility on [DATE] from the hospital for rehabilitation. Further review of Resident #6's medical record revealed the Resident had 2 physician certifications that he/she was unable to comprehend information and make decisions on 9/21/25 and 9/23/25. Further review of Resident #6's medical record revealed a Social Services Note on 10/23/25 at 9:56 AM by Staff #6 that stated the Resident's representative reported that he/she would like for the Resident to discharge before the discharge already set by the Director of Rehabilitation due to wanting the Resident to be home. The Resident's RP stated he/she would be in touch with Social Services regarding a discharge date . During interview with Staff #6 on 1/12/26 at 12:18 PM, Staff #6 stated she did tell the RP they needed to sign the Against Medical Advice (AMA) form since the Resident could not and he/she was the RP. Staff #6 provided the AMA form to the Surveyor. Review of the AMA form revealed the RP wrote The facility wrote that if I don't sign this paper, they will not let the Resident leave the facility. It was signed by the RP and Staff #6 on 10/29/25. Review of an email, provided by the facility, sent to Resident #6's RP by Staff #6 on 10/28/25 at 3:31 PM revealed it stated: We can send you the discharge paperwork prior to his/her discharge, but we would need you to sign and send it back in order for us to discharge the Resident on Thursday (10/30/25). Interview with the Corporate Nurse on 1/13/26 at 10:30 AM, the Corporate Nurse confirmed she told Staff #6 via email on 10/30/25 the RP did not need to sign the AMA document. The Surveyor advised the Corporate Nurse at that time the RP had already signed the document on 10/29/25. During interview with Resident #6's RP on 11/14/26 at 11:39 AM, the RP stated he/she had emailed the facility on 10/28/25 to tell them he/she had arranged transportation home for the Resident on 10/30/25. The RP stated at that time Staff #6 emailed him/her back and said he/she could not take the Resident home unless he/she signed the discharge paperwork and included an AMA (Against Medical Advice) document. The RP stated he/she didn't believe the facility could hold the Resident if he/she wanted the Resident to go home. The RP stated he/she did sign the document on 10/29/25 and returned it to the facility but marked on the document the facility he/she was signing because the facility said they would not discharge the Resident unless he/she signed.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on medical record review, observation, and interview, it was determined the facility failed to ensure that the resident's call light and commonly used items were within reach, per the individualized care plans, to allow access to assistance when needed. This was evident for 1 (Resident #12) of 19 residents reviewed during a complaint survey. The findings include:A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care.On 1/12/26 at 10:12 AM Resident #12's medical record was reviewed and revealed Resident #12 was admitted in November 2024 with diagnoses that included but were not limited to unspecified dementia, repeated falls, and multiple sclerosis. Review of Resident #12's care plan, actual fall and is at risk for falls related to generalized weakness and gait/balance problems that was initiated in November 2024, had the intervention, have commonly used articles within easy reach i.e. call bell, TV remote control, etc. On 1/12/26 at 11:26 AM observation was made of Resident #12 lying in bed covered with a white sheet and white blanket. The gray call bell cord was hanging on the wall and not within reach of the resident. Resident #12's over the bed tray table was next to the window and out of reach of the resident. On the bed tray table was water, sandwiches, and the tv remote control.On 1/12/26 at 11:26 AM an interview was conducted with LPN #4 the Unit Manager of the second floor. LPN #4 was asked where Resident #12's call bell was located. LPN #4 looked around the bed, walked next to the bed and saw the call bell hanging on the wall. LPN #4 took the call bell cord off the wall and placed it on top of the bed. LPN #4 was asked if the tray table should have been within reach for Resident #12 and he said, yes. LPN #4 then pushed the tray table next to the resident's bed.On 1/13/25 at 9:35 AM a second observation was made and on 1/13/26 at 12:25 PM a third observation was made of Resident #12. The gray call bell cord with attached call bell was lying on the floor out of the resident's reach. Staff #14 was shown the concern.On 1/13/25 at 12:35 RN #15 was informed of the concern.

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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. Based on review of facility reported incidents, medical record review and staff interview, it was determined the facility failed to thoroughly investigate an allegation of abuse . This was evident for 1 (Resident #7) of 9 residents reviewed for Facility Reported Incidents during a complaint survey.The findings include: A review of facility reported incident 367211 was conducted on 1/6/26 regarding an allegation Resident #7 reported to Staff #18 on 5/13/25 that he/she was uncomfortable the way Staff #17 cared for him/her on 5/10/25. On the initial report to OHCQ (Office of Health Care Quality) submitted on 5/13/25 the facility indicated the allegation was physical. Further review of the facility investigation revealed no statement from Staff #18 to include what was reported by Resident #7 and when it was reported. The investigation also did not include a statement from Resident #7 until 5/14/25, the day after the allegation. Review of the statement provided by Resident #7 on 5/14/25 revealed the Resident stated to the Social Services Assistant (SSA) that the Resident saw Staff #17's fingers in his/her private area. Further review of Resident #7's medical record revealed the Resident was seen by Staff #19 (Psychiatric Mental Health Nurse Practitioner) on 5/14/25 who documented the Resident reported the allegation on 5/13/25 to the Dietitian. Review of the facility investigation provided to the Surveyor on 1/12/26 reveals no statement from the Dietitian and no emergency room documentation. After Surveyor intervention on 1/12/26, the facility provided the Surveyor with a copy of Resident #7's emergency room documentation from 5/13/25 that was not in the Resident's medical record. Review of the emergency room physician notes dated 5/13/25 revealed it stated the Chief complaint (in patient's own words) was for a complaint of sexually assaulted by male staff last Saturday at around 8:00 PM. Review of the Facility Reported Incident Follow-Up Investigation Report Form submitted on 5/20/25 by the Administrator did not include the Resident's statement alleging sexual abuse. Interview with the Corporate Nurse on 1/13/26 at 12:05 PM confirmed the investigation for Resident #7's allegation of sexual abuse on 5/13/25 does not include interviews, emergency room documentation and a complete investigation of the Resident's allegation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 4 (#12, #10, #11, #9) of 5 residents reviewed for MDS assessments during a complaint survey.The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident.1) On 1/12/26 at 10:12 AM a review of Resident #12's medical record was conducted. A review of a 7/14/25 at 12:36 PM care plan update note documented, resident had an unwitnessed fall on 7/11/25 at around 1530. Resident was observed on the floor between the beds by a GNA during rounds.Review of Resident #12's annual MDS assessment with an assessment reference date (ARD) of 10/1/25, Section J1800 Falls, coded that Resident #12 did not have any falls during the previous 3 months. The facility failed to capture the fall on 7/11/25.On 1/13/26 at 12:35 PM an interview was conducted with the MDS Coordinator, RN #16 who confirmed the findings of the MDS errors.2a) On 1/12/26 at 10:52 AM a review of Resident #10's medical record was conducted. A review of nursing progress notes dated 7/30/25 documented that Resident #10 had an unwitnessed fall on 7/30/25 around 6:20 AM. Resident #10 did not sustain any injuries.Review of an 8/1/25 care plan update note documented Resident #10 had an unwitnessed fall on 7/31/25 at 1735 (5:35 PM). There were no noted injuries.Review of Resident #10's MDS assessment with an ARD of 8/22/25, Section 1800 Falls, coded no falls since last assessment. The facility failed to capture the 2 falls.Further review of Resident #10's medical record revealed the August 2025 Medication Administration Record (MAR) which documented Resident #10 received PRN (when needed) Oxycodone for pain on 8/16/25 and 8/18/25. The Treatment Administration Record (TAR) documented that Resident #10 received the antibiotic ointment Bacitracin on 8/15, 8/16, and 8/17/25.Review of Section J0100B received PRN pain medications OR was offered and declined? It was coded 0. The facility failed to capture the PRN use of Oxycodone.Review of Section N Medications, N0415, High-Risk Drug Classes was blank for antibiotic use. The facility failed to capture the use of Bacitracin ointment.2b) Review of Resident #10's care plan update note dated 9/15/25 at 10:10 M documented, had a fall while bathing, no injury noted.Review of the MDS assessment dated [DATE], Section J1800 falls, failed to capture the fall of 9/15/25. On 1/13/26 at 12:35 PM RN #16 confirmed the findings of the MDS errors.3) On 1/12/26 at 11:04 AM a review of Resident #11's medical record was conducted. A review of Resident #11's December 2025 MAR documented Resident #11 received Aspirin (antiplatelet) every morning and Gabapentin (anticonvulsant) every evening.Review of Resident #11's MDS ARD of 12/17/25, Section N Medications, N0415, High-Risk Drug Classes was blank for antiplatelet and anticonvulsant. The facility failed to capture the use of the medications.On 1/13/26 at 12:35 PM RN #16 confirmed the findings.4) On 1/12/26 at 12:05 PM a review of Resident #9's medical record was conducted. Review of Resident #9's February 2025 MAR documented the administration of Tramadol every day for pain 30 minutes before therapy. Resident #9 received the Tramadol on 2/10, 2/11, and 2/12/25. Tramadol is an opioid used for moderate to severe pain.Review of the MDS assessment with an ARD of 2/14/25, Section N Medications, N0415, High-Risk Drug Classes was blank for opioid use. The facility failed to capture the use of opioids. On 1/13/26 at 12:35 PM an interview was conducted with the MDS Coordinator, RN #16 who confirmed the findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and staff interview it was determined that facility staff failed to develop and initiate a comprehensive, resident centered care plan for a resident with an indwelling urinary catheter. This was evident for 1 (Resident #15) of 5 residents reviewed for urinary catheters during a complaint survey.The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. A foley catheter is a flexible tub placed in the body which is used to empty the bladder and collect urine in a drainage bag. Obstructive uropathy occurs when urine cannot drain through the urinary tract. Urine backs up into the kidney and causes it to become swollen. Reflux nephropathy is a condition in which the kidneys are damaged by the backward flow of urine into the kidney. On 1/13/26 at 12:20 PM observation was made of Resident #15 lying in bed with foley catheter tubing and a drainage bag hanging on the side of the bed. The urinary drainage bag was not in a dignity bag.Review of Resident #15's medical record revealed the resident was admitted to the facility in September 2025 with diagnoses that included but were not limited to obstructive and reflux uropathy, malignant neoplasm of rectum, and benign prostatic hyperplasia.Further review of Resident #15's medical record failed to produce a care plan with measurable goals and interventions for a resident with a foley catheter.On 1/13/26 at 12:35 PM RN #15 was interviewed and stated the resident should have had a care plan for the catheter and she said she would make sure a care plan was put in place.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, observation, and interview, it was determined the facility staff failed to ensure fall mats and the resident's call bell were properly in place for a resident with a history of falls. This was evident for 1 (Resident #12) of 19 residents reviewed during a complaint survey.The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 1/12/26 at 10:12 AM a review of Resident #12's medical record revealed Resident #12 had been a resident of the facility since November 2024 and had diagnoses that included but were not limited to unspecified dementia, repeated falls, and multiple sclerosis. Review of a 7/14/25 at 12:36 PM note documented that Resident #12 had an unwitnessed fall on 7/11/25 at around 1530. The resident was observed on the floor between the beds by a GNA (geriatric nursing assistant) during rounds. The fall was reviewed by the interdisciplinary team, and they continued with a plan of care. Review of Resident #12's care plan, actual fall and is at risk for falls related to generalized weakness and gait/balance problems, that was initiated in November 2024, had the intervention, have commonly used articles within easy reach i.e. call bell, TV remote control, etc. and fall mat at bedside when in bed unattended as tolerated. On 1/12/26 at 11:26 AM observation was made of Resident #12 lying in bed covered with a white sheet and white blanket. The gray call bell cord was hanging on the wall and not within reach of the resident. Resident #12's over the bed tray table was next to the window and out of reach of the resident. On the bed tray table was water, sandwiches, and the tv remote control. There were no fall mats on the floor next to the bed.On 1/12/26 at 11:26 AM an interview was conducted with LPN #4 the Unit Manager of the second floor. LPN #4 was asked where Resident #12's call bell was located. LPN #4 looked around the bed, walked next to the bed and saw the call bell hanging on the wall. LPN #4 took the call bell cord off the wall and placed it on top of the bed. LPN #4 was asked if the tray table should have been within reach for Resident #12 and he said, yes. LPN #4 then pushed the tray table next to the resident's bed.On 1/13/26 at 12:25 PM a second observation was made of Resident #12. The gray call bell cord with attached call bell was lying on the floor out of the resident's reach. There were no fall mats on the floor next to the bed. Staff #14 was shown the concern.On 1/13/26 at 12:35 RN #15 was informed of the concern.

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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 medical record review, interview, and observation, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 3 (Resident #8, #14, #7) of 19 residents reviewed during a complaint survey.The findings include: A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1) On 1/12/26 at 9:30 AM a review of Resident #8's medical record was conducted. Review of the census section of the medical record revealed on 9/18/25 Resident #8's room was switched from room [ROOM NUMBER] to room [ROOM NUMBER]. Review of a 9/23/25 psychotherapy note documented that the resident loved his/her new room and found it more calming and stated he/she was doing okay and adjusting to the new environment. Review of the miscellaneous section, assessment section, and progress notes section of the medical record failed to produce any documentation about the room change or the request to change rooms. Review of Resident #13's (the new roommate) medical record did not have any documentation of receiving a new roommate on 9/18/25. On 1/12/26 at 11:50 AM an interview was conducted with the Social Work assistant, Staff #6 who said there should have been a roommate notification assessment in the assessment section of the medical record under new roommate transfer form. For Resident #8 the only roommate assessment form in the medical record was dated 12/17/24. For Resident #13 the only roommate assessment form was dated 5/28/21 and 1/19/22. On 1/12/26 at 12:17 PM Staff #6 came back and gave the surveyor a handwritten transfer form that she said was located in the Director of Nurse's (DON) office. She confirmed it was not in the medical record and stated she did not know why it was in the DON's office. On 1/12/26 at 12:23 PM the Interim DON was asked why the forms would be in her office and not in the medical record. She stated that it should have been in the medical record and didn't know why it was not. 2) On 1/13/26 at 12:14 PM observation was made of Resident #14 lying in bed. Resident #14 had a foley catheter and the drainage bag was hanging on the left side of the bed. The drainage bag was not in a dignity bag and urine was visible. A foley catheter is a flexible tube placed in the body which is used to empty the bladder and collect urine in a drainage bag. Drainage bags can be placed in a privacy/dignity bag to enhance privacy to the resident to hide the fluid that is being drained from the body. Review of Resident #14's January 2026 Treatment Administration Record (TAR) documented the physician's order, catheter care: ensure dignity foley bag is in use every shift. The order was written on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/11/26. Further review of the 2026 TAR documented on 1/11/26, 1/12/26, and 1/13/26 nurse's initials each shift that indicated the foley catheter drainage bag was in a dignity bag. The licensed nurses on all shifts for 3 days falsely documented the use of a dignity bag. On 1/13/26 at12:35 PM RN #15 was shown the foley catheter bag and lack of a dignity bag. RN #15 confirmed the findings. 3) A review of Resident #7's medical record was conducted on 1/12/26 for a complaint the Resident went to the hospital on 5/13/25 for an allegation of sexual abuse. Review of Resident #7's assessments, progress notes, documents and paper medical record on 1/12/26 revealed no documentation the Resident went to the emergency room on 5/13/25. During interview with the Acting Director of Nursing on 1/12/26 at 11:00 AM, the Surveyor informed the Acting Director of Nursing that there was no documentation for the Resident going to the emergency room on 5/13/25 in the medical record. On 1/12/26 at 12:22 PM, the Acting Director of Nursing provided the Surveyor with the emergency room visit documentation on 5/13/25 for Resident #7. At that time the Acting Director of Nursing stated she had to obtain the document from CRISP (a regional health information exchange). The Acting Director of Nursing confirmed there was no documentation of the emergency room visit on 5/13/25 for Resident #7 in his/her medical record.