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

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 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. 44440 Based on observation and interview with residents and staff, it was determined that the facility failed to maintain a residents' dignity. This was found of 1 (Resident #40) resident on a random observation. The findings include: On 1/16/25 at 12:01 PM, the surveyor knocked and asked to enter into Resident #40's room. Resident #40 responded, yes. Next the surveyor observed Resident #40 with an open depends laying flat in the bed. The surveyor asked if Resident #40 needed any help. Resident #40 stated that he/she had just put on the call light to have incontinent care provided. He/she further stated that a staff member came in, turned off the light, and stated that they would get the person assigned to assist in cleaning up. Resident #40 stated that he/she had a full depends and could not get up on his/her own. On 1/16/25 at 12:07 PM, 6 minutes later, the surveyor observed Geriatric Nursing Assistant (GNA) #25 walk right into the room without knocking or asking permission to come in. GNA #25 stated she was there to help Resident #40 with incontinent care. The surveyor asked the GNA how long it had been since Resident #40's call light was turned off and GNA#40 stated it had been 10 minutes. The surveyor asked GNA #25 if she normally knocks before entering into a resident's room. GNA #40 stated that she usually does but did not this time. On 1/16/25 at 12:20 PM, the surveyor reviewed the observation with the 2nd floor Unit Manager #6. UM#6 confirmed the GNA #40 should have knocked before entering.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 51589 Based on observations and staff interviews, it was determined that the facility failed to ensure residents had access to, and appropriate call bells. This was found to be evident in 2 (Resident #9 and Resident #333) of 52 residents reviewed for access to the call system during the recertification survey. The findings include: 1) On 1/7/2025 at 10:00 AM, surveyors observed Resident #333 did not have a call bell in their room. Surveyors interviewed Geriatric Nursing Assistant (GNA) #12 at 10:01 AM and asked about the call bell for the resident. GNA #12 confirmed to surveyors that the resident did not have a call bell available and informed that the room needed a splitter for the outlet that would allow for 2 call bells (Resident #333's roommate had a functioning call bell). GNA #12 stated they would update their Unit Manager about the situation to correct. Further observations by surveyors at 11:30 AM revealed that Resident #333 had not received a call bell. GNA #12 was questioned by surveyors and stated they alerted their Unit Manager about the situation. At 11:30 AM, surveyors interviewed 3rd floor Licensed Practical Nurse (LPN) Unit Manager #9. LPN #9 stated they would alert maintenance to the situation. At 11:43 AM, LPN #9 stated to surveyors that Resident #333 had received a call bell, and a functioning call bell was observed by surveyors to be next to the resident. 2) On 1/8/2025 at 10:05 AM, surveyors observed and interviewed Resident #9. Resident #9 stated to surveyors that staff did not answer their call bell when pushed earlier in the morning. Surveyors directed the resident to activate the call bell again and observed the resident unable to physically activate the push pad style call bell. At 10:12 AM, GNA #11 was interviewed by the surveyors and was made aware of Resident #9's inability to activate the call bell provided to them. GNA #11 observed the resident attempting to activate without success and stated to the surveyors they would update their Unit Manager. At 10:19 AM, the facility's Maintenance Director entered the resident's room and observed the resident unable to activate their call bell. The Maintenance Director stated to surveyors that they would replace the push pad call bell with a push button. At 10:22 AM, the Maintenance Director replaced Resident 9's push pad call bell with a push button call bell, and the surveyors observed the resident successfully activate the call bell system. An interview was conducted with the Director of Nursing (DON) by surveyors on 1/10/2025 at 9:58 AM. The DON acknowledged the surveyors' concern with call bells and stated the facility's expectation is that call bells are accessible to residents and appropriate call bells are used based on residents' needs.

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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 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51589 Based on medical record review and staff interview, it was determined that the facility failed to code the resident's status accurately on the Minimum Data Set (MDS) assessment. This was found to be evident for 1 (Resident #52) of 8 residents reviewed for accuracy during the recertification survey. The findings include: The MDS is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. Anticoagulant (AC) medication is a type of drug that helps prevent blood clots from forming or growing larger. It is important because it reduces the risk of serious conditions like strokes, heart attacks, or deep vein thrombosis, especially in people with conditions that increase the likelihood of clotting. These medications help keep blood flowing smoothly and prevent harmful blockages in the bloodstream. On 1/13/2025 at 8:44 AM, Resident #52's medical record was reviewed by the surveyors. A physician's order for Apixaban (a type of AC medication) was placed on 7/23/2024 and the resident's care plan included they were on AC medication, initiated on 3/23/2025 and revised on 6/27/2024. Further record review revealed a quarterly MDS assessment dated [DATE] which, under section N for medication, no was documented for AC. An interview was conducted by surveyors with the MDS Coordinator on 1/13/2025 at 10:11 AM. The MDS Coordinator was asked about the quarterly MDS assessment being documented no for AC. The MDS Director stated to surveyors that it was an error AC was incorrectly coded no and stated they would submit a modification of quarterly to MDS to correct the discrepancy. During an interview on 1/13/2025 at 2:15 PM, the Nursing Home Administrator acknowledged concerns with MDS accuracy and provided documentation to surveyors that the resident's MDS was corrected by the facility.

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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. 44440 Based on record review and interview with a resident and staff it was determined that the facility failed to develop a comprehensive person-centered care plan. This was found evident of 1 (Resident #1) of 3 residents reviewed for care planning. The findings include: On 1/8/25 at 8:49 AM, the surveyor interviewed Resident #1. During the interview Resident #1 expressed that he/she was inaccurately assessed and/or diagnosed and that he/she wished to pursue looking into transfer to another facility. On 1/10/25 at 9:16 AM, the surveyor reviewed Resident #1's medical record. The review revealed that on 8/15/24 Psychiatric Nurse Practitioner Staff #37 wrote a progress notes that stated, Resident #1's goals,I want to go to a different nursing home which is closer to a shopping center and metro access because I like to shop. On further review, a Psychologist, Staff #38 wrote a progress note on 10/4/24 that stated, Resident #1 requested to leave the facility for several hours to go shopping. Staff #38 wrote in the note, my clinical impression, he/she is safe to do so and is generally good at following structure. However, further in the note Staff #38 expressed that Resident #1 did not have capacity at this time and that Resident #1 would be vulnerable. On 1/13/25 at 10:11 AM, the surveyor reviewed Resident #1's care plan. The review revealed a care plan that was created on 9/22/23 that stated, Resident #1 had a variety of activity interests such as music entertainment, socials, bingo, arts and crafts, poetry and a general willingness to take part in group activity programs. The goal listed was Resident #1 will plan and choose to engage in preferred activities. No mention of request or desire to go shopping was noted in the care plan. A care plan was created on 7/10/24 by Social Service Director #16 that stated, Resident #1's anticipates remaining in the facility long-term. The goal listed was Resident #1 will receive effective treatments throughout the review at the facility. Resident #1 will participate in his/her care decisions for my long-term stay and will be able to voice satisfaction with the care received while remaining in this facility through this review period. On 1/4/25 at 11:04 AM, the surveyor interviewed the Social Service Director Staff #16. During the interview Staff #16 stated that Resident #1 expressed a desire to be transferred to other facilities earlier in 2024 and that she had sent in referral documents to other facilities. She also stated that Resident #1 had expressed an interest in going out shopping earlier in the summer months. She further stated that she offered for Resident #1 to go out with an escort. The surveyor asked if Staff #16 had documented these changes in the care plan or anywhere in Resident #1's medical record. She stated she would look and follow up. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 1:15 PM, the surveyor conducted a follow-up interview with Staff #16. During the interview Staff #16 brought in email correspondence dated 7/3/24 and 9/3/24 to another facility regarding transferring and a two typed statement from the days she spoke with Resident #1 about shopping trip availability and desire dated 7/1/24 and 9/11/24. The surveyor noted that Resident #1 requested to be transferred on 7/3/24 and yet the care plan created on 7/10/24 stated Resident #1 plan was to remain in the facility in long term care. On 1/21/25 at 12:11 PM, the surveyor conducted an interview with the Director of Nursing (DON) and Staff #16. During the interview the surveyor reviewed the concerns that Resident #1's care plan was not updated and/or person centered with Resident #1's expressed goals for his/her plan of care regarding discharge planning and activities goals and interventions.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50385 Based on resident interviews, observations, record review and staff interview, it was determined that the facility failed to ensure the residents had safety equipment in working condition. This was evident for 1 (Resident #58) of 9 residents reviewed for accidents and hazards. The findings include: On 1/08/25 at 10:24 AM, an interview was conducted with Resident #58. Resident #58 stated they fell recently and stated that they believe it was due to a handrail on the toilet being broken. In an observation during the interview, there was a handrail on each side of the wall and handrails attached to each side of the toilet. The handrail attached to the left side of the toilet was broken. Staff #4 was notified of the concern and stated this was the 1st time notified of the issue and maintenance would be notified immediately. On 1/09/25 at 12:10 PM, an observation was conducted with Resident #58's room. The handrail on the toilet was visualized and was still broken. This surveyor notified the Administrator of the broken handrail attached to the toilet in room [ROOM NUMBER]. The Administrator stated that the handrail would be taken care of immediately. On 1/09/25 at 12:23 PM, a review of Resident #58's records was conducted. A change of condition assessment from 12/14/24 showed that the resident's last fall was 12/13/2024. Under the summary section for the assessment stated that Resident #58 had stated they fell when attempting to use the restroom the day prior. An Xray was ordered on 12/14/2024 and no fracture was revealed. On 1/09/25 at 1:14 PM, a review of Resident #58's care plans were conducted. The resident has a care plan for falls and it was revised on 12/16/24 with an intervention to anticipate the needs of the resident. 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 they Prioritize the severity of repairs and attend to them 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 handrails were removed for safety and they had hand rails on the wall for the resident to use instead.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 51589 Based on observations, record reviews, and interviews, it was determined that the facility administered oxygen to a resident without an order. This was found to be evident in 1 (Resident #9) of 2 residents reviewed for oxygen administration during the recertification survey. The findings include: On 1/10/2025 at 8:17 AM, surveyors observed Resident #9 to be on oxygen through nasal cannula via an oxygen concentrator in their room. Previous observations of Resident #9 on 1/8/2025 did not reveal the resident to be on oxygen. Resident #9's medical record was reviewed by surveyors at 8:30 AM. A Change of Condition assessment note dated 1/9/2025 at 11:00 PM documented that Resident #9 had low oxygen saturations and the Nurse Practitioner (NP) #33 on duty was contacted by staff. The assessment note stated that Resident #9 was to be started on oxygen at 3 liters via nasal cannula per NP #33. Further review of Resident #9's record did not reveal an order in their chart for oxygen administration. Surveyors interviewed Licensed Practical Nurse (LPN) #10 on 1/10/2025 at 8:47 AM and asked about the oxygen administration for Resident #9. LPN #9 stated they were not sure when the resident was placed on oxygen and that their expectation is that residents on oxygen should have an order in their Electronic Health Record (EHR). LPN #9 confirmed to surveyors that they did not see an order for oxygen for Resident #9 in the EHR. At 8:52 AM, 3rd floor Licensed Practical Nurse (LPN) Unit Manager #9 was interviewed by surveyors. LPN #9 could not find an order for oxygen administration in Resident #9's EHR and stated it is their expectation that there should be an order in residents EHR if they are on oxygen. Surveyors interviewed the Assistant Director of Nursing (ADON) at 8:56 AM about Resident #9 being on oxygen. The ADON stated that the oxygen was likely verbally ordered by NP #33 and that it is the nursing staff's responsibility to place the order in the EHR. The ADON stated to surveyors that they would update the oxygen order for Resident #9. Further review of Resident #9 medical records by surveyors on 1/10/2025 at 9:36 AM revealed an updated order to administer continuous oxygen at 3 liters via nasal cannula for shortness of breath/low oxygen saturation. On 1/10/2025 at 9:58 AM, surveyors interviewed the Director of Nursing (DON) addressed concerns of Resident #9 receiving oxygen without an order in their EHR. The DON acknowledged the concern and stated that they were having the nurse responsible for placing the verbal orders for oxygen by NP #33 come into the facility for a teaching conference.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 51589 Based on staffing record review and staff interviews, it was determined that the facility failed to provide a Registered Nurse (RN) for 8 consecutive hours. This was found to be evident for 1 of 21 days reviewed for RN staffing during the recertification survey The findings include: Prior to the recertification survey, review of the Payroll Based Journal (PBJ) by the surveyors did not identify any staffing waivers. During the entrance conference on 1/7/2025 at 9:47 AM, it was confirmed to surveyors by the Nursing Home Administrator (NHA) that the facility did not currently have any staffing waivers in place. On 1/15/2024 at 11:30 AM, surveyors reviewed the daily nursing staffing sheets provided by the facility from 12/24/2024 to 1/13/2025. It was revealed that on 1/1/2025, there was no RN scheduled for the night, day, or evening shifts. The Director of Nursing (DON) was interviewed by surveyors on 1/15/2025 at 12:45 PM. The DON stated that they were not aware of any staffing issues since they have been at the facility, and it is the DON and Assistant Director of Nursing (ADON) who are responsible for RN coverage if a scheduled RN calls out or there is an RN shortage. Surveyors addressed concern to the DON about no RN coverage on 1/1/2025 and requested 24-hour staff and agency punch in sheets dated 1/1/2025. The DON stated they would supply these documents. On 1/16/2025 at 9:20 AM, the ADON was interviewed by surveyors. The ADON stated that they were the RN on call on 1/1/2025 and available by phone but were not physically present in the facility on that day. Review of 24-hour staff punch in sheets did not show a RN was clocked in on 1/1/2025. The facility's Staffing Coordinator was interviewed by surveyors on 1/16/2025 at 11:07 AM who stated that it is the facility's expectation to have an RN in the building for 8 consecutive hours a day. Surveyors asked about RN staffing on 1/1/2025 and the Staffing Coordinator confirmed there was no RN scheduled for 8 consecutive hours on that day, and that the ADON was on call and available through the phone.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50385 Based on record review and staff interviews, it was determined that the facility failed to ensure that physicians document that they reviewed the pharmacist's identified the irregularities and failed to ensure that physicians documented the action taken or not taken to address the irregularities. This was evident for 2 (Resident #38 and #51) out of 5 residents reviewed for unnecessary medications. The findings include: On 1/10/25 at 9:22 AM, a review of Resident #38 and #51's records was conducted. Resident #38 was ordered Trazodone, an antidepressant, to be given for Depression. According to records, there was a pharmacist review with recommendations to Resident #38's medication regimen on 9/20/24, 6/14/24, and 5/7/24. Resident #51 was ordered Sertraline, a Selective Serotonin Reuptake Inhibitor (used to treat depression), and Mirtazapine, an antidepressant. On 1/9/25 at 9:25 AM, This surveyor requested the pharmacist medication recommendation for Resident #38 conducted on 9/20/24, 6/14/24, and 5/7/24; and requested pharmacist medication recommendation for Resident #51 conducted on 9/20/24 and 6/14/24 from the Director of Nursing (DON). On 1/10/25 at 11:45 AM, an interview was conducted with the DON. The DON stated that the Physician failed to document that they reviewed the pharmacist's identified irregularities and failed to document the action taken or not taken to address the irregularities. On 1/14/2025 at 12:46 PM, An interview was conducted with Medical Director (Staff #35). When asked what his expectations were for reviewing and implementing changes to the medication regimen after a pharmacist reviews and/or recommends changes, Staff #35 stated that this should be done in a timely fashion. When asked what a reasonable time is, Staff #35 stated that within a week or so is a reasonable amount of time. Providers are in the building weekly so they should be reviewing the pharmacy reviews on their visits. The nursing staff will also be called and notified, and providers can give verbal orders for the recommendations. When asked where the providers can document that the pharmacist reviews were reviewed; Staff #33 stated that if the doctor did not agree with the pharmacist recommendation, Staff #33 doesn't know that there is a specific place where they would document it. When asked that if a MD does not document rationale, how is the facility to know that the recommendation was just not ignored vs not agreed with; Staff #33 stated, I do see the sheets that are printed with the recommendation and decision made. (continued on next page)

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	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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 10:15 AM, an interview was conducted with Staff #33. When asked how the providers in the facility review the pharmacist review of each resident's medication regimen, Staff #33 stated the DON sends the recommendations to the providers to review them. Once reviewed there is a PDF document from the pharmacy that the providers document whether they agree or disagree with their recommendations. The provider would then sign the document and send it to the DON for follow-up. When asked if this document is placed in the residents' hard chart or uploaded to the residents' electronic chart or is the review documented in the resident's chart; Staff #33 stated that if a change is recommended and agreed on, they will add or change the orders and write notes to coincide, but if no changes then no notes or documentation would be made in the resident's chart.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 44440 Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that a resident's medication regimen was free from unnecessary medication. This was found evident in 1 (Resident #1) out of 8 residents reviewed for medications. The findings include: On 1/8/25 at 8:49 AM, the surveyor interviewed Resident #1. During the interview Resident #1 expressed that he/she was not getting the correct doses of medications. On 1/13/25 at 9:45 AM, the surveyor reviewed the May 2024 Medication Administration Record. On May 1st, 2nd, 3rd, and 4th it was documented that Resident #1 received 88 micrograms of levothyroxine Sodium (a medication used to treat hypothyroidism, a condition where the thyroid gland does not produce enough thyroid hormone) at 6:30 AM. On further review it was noted an additional dose of Levothyroxine Sodium 88 micrograms was given on May 1st, 2nd, 3rd, and 4th at 9 AM, the combined dose was 188 micrograms for those 4 days. On 1/14/25 at 1:20 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor asked if Resident #1 was intended to get two different administrations of the same medication, levothyroxine May 1st-4th. The DON confirmed that the two administrations were given in error and education would be provided to the staff.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 50385 Based on record review and staff interview, it was determined that the facility failed to ensure that radiology services were set up to meet the resident's needs and scheduled in a timely manner. This was evident for 1 (Resident #88) out of 1 resident reviewed for radiology services. The findings include: On 1/21/25 at 10:30 AM, a review of Complaint #MD00199976 was conducted. The complaint stated that Resident #88's discharge was delayed due to poor coordination of staff to plan transportation and appointments prior to discharge. On 1/22/25 at 10:36 AM, a review of Resident #88's progress notes were conducted. According to physicians and nursing notes, the resident had complained of left knee pain on 10/10/23. An Xray was completed on 10/10/23 to rule out a fracture, and the Xray did not show any signs of fractures but did show left knee joint effusion. On 10/13/23, a physician's note stated that the resident would need an orthopedic surgery consultation. After the orthopedic surgery consult appointment on 10/23/23, an ultrasound of the knee was ordered for 11/20/23. On 11/7/23, an Magnetic Resonance Imaging (MRI) of the knee was ordered for 11/20/23. On 11/20/23, the ultrasound and MRI were not done due to improper sling on the resident's wheelchair. The rescheduled appointment for MRI and ultrasound was set for 12/1/23. On a nursing note on 11/30/23, the resident's MRI and ultrasound was canceled because the Doctor had an order in place stating the resident would not be able to tolerate an MRI and the radiology provider stated they do not offer ultrasounds as a service. On 12/8/23, nursing noted that they are still looking to create an appointment for the resident's ultrasound. On 12/11/23, the MRI was conducted. On 1/21/25 at 9:50 AM, an interview with Staff #32 was conducted. When asked when they review orders for transportation how do you know the type of transportation needed for a resident, they stated that they will verbally communicate with the unit managers to find out what the needs for the resident are. When asked if it is their expectation that the information provided by the unit managers is accurate, Staff #32 stated, yes.

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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. 51713 Based on observation, record review, and interview it was determined that the facility failed to maintain accurate orders in a resident's medical record. This was evident for 1 (Resident #380) of 52 residents reviewed during the annual survey. The findings include: Medical records must be maintained for accuracy in a manner that is consistent with resident's needs, medical history and physical. On 1/08/25 at 9:30 AM, surveyors observed Resident #380 in bed with bilateral below the knee amputations (BKA). On 1/15/25 at 9 AM the surveyor conducted a record review which revealed a history and physical progress note dated 1/05/25 that stated the resident was admitted to the facility with bilateral BKAs. Further review of the medical record showed an active physician's order to Float heels when in bed as tolerated every shift for Preventative Skin Measures. Review of the treatment administration record revealed that facility staff documented this order as performed three times daily from 1/03/25-1/14/25. On 1/15/25 at 09:54 AM surveyors and a licensed practical nurse (LPN), LPN #19, reviewed Resident #380's treatment administration record. Surveyors asked LPN #19 if the order to float heels was accurate. LPN #19 disagreed and stated, no it is not accurate Resident #380 does not have heels. The surveyors asked LPN #19 if the order will remain in the resident's chart and LPN #19 replied no, the order will be discontinued immediately. During exit conference on 1/22/25 at 2 PM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were made aware of the concern that the medical record was inaccurate.

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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.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44440 Based on record review and interviews it was determined that the facility failed to have an effective pest control program. This was found evident on 1 of 3 floors. The findings include: On 1/8/25 at 8:37 AM, the surveyor conducted an interview with Resident #1. During the interview Resident #1 reported that he/she had observed cockroaches in his/her drawer a few months back and the facility had to have someone come in to take care of them. On 1/10/25 at 9:38 AM, the surveyor interviewed the Nursing Home Administrator (NHA). During the interview the NHA confirmed that in late October or November an exterminator came to the facility to treat rooms for cockroaches. The surveyor asked for the facility's pest management log and reports. On 1/13/25 at 10:59 AM, during an interview with Resident #29's family member it was reported that the family member saw a cockroach in their father/mother's room. On review of the documents provided by the NHA, a Special Service Record was given and the description on the forms stated, this form [should be used] to reported problems which occur between routine scheduled service visits. The form had serviced dates of 9/16/24, 10/10/24, 10/28/24, 11/4/24, 12/2/24, and 12/17/24. 5 out of the 6 dates mentioned roaches as the problem. Additionally, the NHA gave a special agreement document, without a date or signature, that described treatment as, roach flashout service for 48 rooms with 5 times service. No additional documents were provided. On 1/15/25 at 11:44 PM, the surveyor conducted an interview with the NHA. During the interview the NHA stated he had no additional documentation of the routine pest control visits. He confirmed that he was unaware of additional reports or as to what was completed, found or recommended the facility should do after or between each visit.