STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215144	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Care at South Mountain	141 South Main Street Boonsboro, MD 21713

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 18819 Based on complaint, closed record review and staff interview, it was determined that the facility failed to notify Resident #217's representative in a timely manner after a significant change occurred. This was evident for 1 out of 24 complaints reviewed during an annual certification survey. The findings include: On 12/17/24 Complaint MD00179215 was reviewed involving Resident #217. An allegation that Resident #217's family was not immediately made aware of a change in condition that occurred during the morning of 02/28/22 was investigated. Resident #217 was admitted to the facility during the afternoon on 02/25/22 with diagnoses that included an acute embolic stroke, expressive and receptive aphasia, paralysis in the extremities, a new feeding tube, and a Foley catheter. A review of Resident #217's closed medical record on 12/17/24 revealed a nurses note, dated 02/28/22 at 6:52 AM, that indicated a GNA (geriatric nursing assistant) staff member informed the charge nurse, staff member #19, that Resident #217 was observed with a large amount of emesis. Staff member #19 documented that Resident #217's tube feeding was stopped and that the on-call physician was called. Staff member #19 also documented that the on-call physician did not answer the phone call and that the night shift nursing supervisor (staff member #17) was notified and that Resident #217's day shift nurse would also be notified. In an interview with the 02/27-28/22-night shift supervisor (staff member #17) on 12/20/24 at 8 AM, staff member #17 stated that S/he had reviewed Resident #217's closed medical records but could not recall seeing Resident #217 during the night shift on 02/28/22. Staff member #17 stated that S/he usually would write a nursing progress note if a staff nurse calls her/him during the shift to come and assess a resident. Staff member #17 confirmed that there was not a progress note from him/her for Resident #217 during the early morning hours of 02/28/22. Further review of Resident #217's closed medical record revealed a nursing skilled charting -V3 that was initiated at 7:01 am on 02/28/22 and closed/locked at 3:43 PM on 02/28/22. At 10:58 am on 02/28/22, the nursing skilled note indicated that Resident #217 had an oxygen saturation level of 88% while receiving oxygen via nasal cannula, a heart rate of 115 beats per minute, was anxious and agitated, his/her abdomen was distended and firm with hypoactive bowel sounds, and noted that Resident #217 had emesis x 7 this shift and was to be seen by the facility nurse practitioner. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's records showed that Resident #217's representative was called on 02/28/22 at 1:08 PM, and a message was left for the representative to call the facility staff.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 30428 Based on review of medical records, facility policies, investigation documentation, and interviews, it was determined the facility failed to ensure that allegations involving abuse were reported to the State Agency no later than 2 hours after the allegation was made and results of all investigations were reported within 5 working days. This was evident for 5 (Resident #421, #214, #468, #469, #264) of 13 residents reviewed for abuse allegations. The findings include: 1) a. Review of a complaint from 2/1/23 on 12/19/24 at 11:51 AM revealed that resident's family member was notified by the facility that Resident #421 had a fall from [resident] shoes and was sent to the emergency room where a cat scan was completed. Resident #421 at the time of the fall had diagnosis including dementia, muscle wasting and Alzheimer's disease. S/he was also residing in the secure unit of the facility. Care plan and GNA task list report had resident documented as requiring 2 staff for transfers. Review of the nursing progress notes completed on 1/23/23 at 11:04 AM noted that Resident #421 was found on the floor in his/her room, right forehead swollen, vital signs stable. The area was not documented as bleeding, however the resident reported that the area was sore and was noted guarding their forehead and stated oooh that really hurts. On 12/19/24 at 2:24 PM the Director of nursing was asked if this fall, an injury of unknown origin, was reported to the state agency as they did not know at the time how the resident fell . She stated that she was not here at the time, so she did not know. She was further asked if she could look and see as there was no record with the state agency that this fall was reported. This surveyor reported at the time of the concern that there should be a report to the office. b. Continued review of the progress notes for Resident #421 then revealed that on 1/28/23 another fall with significant injury. According to the progress notes entered on 1/28/23 at 10:30 AM, Resident #421 was found lying on the floor in front of his/her bed. S/he had complaints of pain on the right leg and hip. An x-ray was ordered. According to an interview completed on 12/20/24 at 8:00 AM with staff #7, who was the Unit manager at the time, the x-ray was delayed so Resident #421 was sent to the hospital where x-rays were completed and determined that Resident #421 had a femur fracture. Staff #7 was also asked at the time if either fall from 1/23/23 or 1/28/23 was reported to the state agency. She stated that she knows the second fall was reviewed under quality assurance as there was a delay with the x-ray, however she did not know about it being reported. She was asked if injuries of unknown origins are reported and she stated yes and agreed that they both should have been reported to the state agency. 16218 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Review of Resident #214's medical record revealed resident had diagnosis of, but not limited to, dementia and anxiety. The Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy and Procedure was provided by the Nursing Home Administrator on 12/17/24. Review of this policy failed to reveal an effective or revision date. This policy indicates allegations of abuse will be reported within 2 hours if there is serious bodily injury but within 24 hours if the allegation does not meet the definition of serious bodily injury. On 12/19/24 review of facility report MD00189201 revealed that on 2/16/23 at 10:00 PM the resident alleged being inappropriately touched by a Geriatric Nursing Assistant on the evening shift. The report was submitted to the state survey agency on 12/17/23 at 11:00 AM. Further review failed to reveal documentation to indicate who the resident made the initial allegation to or that a follow up interview was conducted/attempted with the resident by an individual responsible for conducting the investigation. No documentation was found to indicate when this allegation was initially reported to the Nursing Home Administrator (NHA) or the Director of Nursing (DON). On 12/19/24 at 10:53 AM Surveyor requested a copy of the investigation documentation from the NHA and also requested any additional documentation they may have regarding this investigation that they would like surveyor to review. On 12/19/24 at approximately 1:30 PM the Assistant Director of Nursing (ADON) provided copies and denied that there was any additional documentation to be provided. On 12/19/24 at 1:59 PM Director of Nursing reported she would expect herself or the NHA to be notified immediately of an abuse allegation and would report it to the survey agency if it was an abuse or actual harm within two hours. Surveyor then reviewed the concern regarding the policy stating they have 24 hours to report abuse allegation if it does not meet definition of serious bodily harm. Surveyor also reviewed the concern that there was no documentation of the initial interview or report from the resident and no documentation found to indicate to whom or when the initial allegation was made or who reported it to the NHA or the DON. 50458 3) On 12/12/2024 at 11:52 AM, a review of investigation MD009196714 and review of the facilities self-report form, revealed that the alleged incident with Resident #468 for sexual abuse, occurred between January and April 2023. The facility was made aware of the incident on 9/8/2023 at 4:00 PM. The incident was reported to the State Agency on 9/11/2023 at 10:04 AM. On 12/17/2024 at 10:00 AM, during an interview with the facility Director of Nursing (DON), she verbalized submission of facility reported incident number MD00196714 to the State Agency outside of the 2 hour time frame. 4) On 12/13/2024 at 12:29 PM, a review of investigation MD00203916, and review of the facilities self-report form revealed that the facility was made aware the alleged incident of abuse with Resident #469 on 3/22/2024 at 8:30 AM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The incident was reported to the state agency on 03/22/2024 at 1:47 PM. No other notification to other agencies were documented. There was no documentation that the final report was submitted to the State Agency. On 12/19/2024 at 11:00 AM, during an interview with the Director of Nursing (DON), she verbalized submission of facility reported incident number MD00203916 to the State Agency outside of the 2 hour time frame and there was no final report submitted to the State Agency on file. 45139 5) On 12/19/24 at 9:13 AM review of Intake # MD00182150 revealed that the facility allegation of abuse was made 2/27/2022 on behalf of Resident #264, a long-term resident of the facility. On 12/19/24 a review of the facilities reported incident (FRI) for intake # MD00182150 revealed that the facility was notified on 2/27/2022 at 5:30 PM. However, that the alleged abuse was not reported to the Office of Health Care Quality until 2/28/22 at 11:30 AM. Further review of the FRI revealed that the facility began interviewing staff on 2/27/2022. On 12/19/24 at 2:33 PM the Director of Nursing and the Assistant Director of Nursing confirmed that the alleged incident was not reported within the required 2 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48470 Based on records review and interviews, it was determined that the facility failed to conduct a thorough investigation of an allegation of abuse. This was evident for 4 (Resident #416, #264, #213 #44) in 13 residents reviewed for abuse. The Findings include: 1) Resident #416 was admitted to the facility in late 2022. On 12/19/24 at 7:56 AM, a review of the investigation packet related to MD00203250 was conducted. The review revealed that the resident had an injury of unknown origin to his/her left thigh. The investigation packet also indicated that the resident was not interviewed due to not having the capacity and having a diagnosis of Dementia. Dementia is a general term for a decline in mental abilities that affects a person's daily life. It's characterized by a loss of cognitive functioning, including memory, thinking, and reasoning. The investigation packet also indicated that a head-to-toe assessment was conducted on the resident and documentation was confirmed on 12/19/24 at 8 AM. However, further review of the investigation failed to reveal that other residents with the same capacity and diagnosis were assessed The Director of Nursing (DON) was interviewed on 12/19/24 at 9:14 AM and she indicated that she was not employed at the time of the incident and referred to the Assistant DON (ADON) who was also present during the interview. The concern was discussed with both staff that the investigation did not indicate that other like residents were assessed to complete a thorough investigation. The DON and the ADON reported that they would review the census for the date of the incident and see if a skin sweep/skin assessment was done for the facility. On 12/19/24 at 11:22 AM, a staff member (Staff #7) introduced herself and indicated that she was a unit manager and that she was covering the unit where Resident #416 was residing at the time of the incident. Staff #7 confirmed that she did the assessment only on the resident at the time of the incident and does not know if an assessment was done to the other residents of the unit. At the time of survey exit on 12/20/24 at approximately 3 PM, no further information was provided by the facility to support that a thorough investigation was conducted regarding the incident. 45139 2) On 12/19/24 at 9:13 AM a review of Intake # MD00182150 revealed that the facility received an allegation of abuse on 2/27/2022 from a family member on behalf of Resident # 264, a long-term resident of the facility. Further review revealed the date of the alleged abuse occurred on 2/23/22. On 12/19/24 a review of the facilities reported incident investigation file for intake # MD00182150 revealed that the facility interviewed 6 staff (FRI) members on 2/27/2022. Of the 6 staff interviewed only two staff reported they worked on the same unit, on the same date (2/23/22) of the alleged abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/24 at 9:30 AM review of the staffing schedule for the Antietam [NAME] unit revealed that 10 staff worked on that unit on 2/23/22. On 12/19/24 at 2:33 PM during an interview with the Director of nursing, she confirmed that the employees that worked on the same unit and on the date that the alleged abuse occurred, should be interviewed. She provided no additional information prior to the end of the survey. 16218 3) Review of Resident #213's medical record revealed a May 2024 Brief Interview for Mental Status score of 14 out of 15 indicating the resident was cognitively intact. On 12/19/24 review of facility report MD00206294 revealed that on 5/28/24 at 1:23 PM the Business Office Mananger (Staff #36) made the administrator aware that Resident #213 reported a geriatric nursing assistant was inappropriate during care. Further review of the investigation documentation failed to reveal a statement from Staff #36. The documentation included a summary that indicated the resident was interviewed on 5/31/24, but no documentation was found to indicate an individual responsible for conducting the investigation spoke with the resident about this allegation prior to 5/31/24. On 12/19/24 at 12:08 PM Staff #36 denied knowledge of an abuse report from Resident #213, but confirmed she would report immediately to the administrator if a resident reported staff was rough with them. On 12/19/24 at 1:59 PM the Director of Nursing (DON) reported that if she was made aware of an abuse allegation she would ask the original reporter to provide a statement and would write a statement after an interview of the resident, if able to be interviewed, which would include the date and time of the interview. On 12/19/24 at 2:15 PM surveyor reviewed the concern with the DON that no documentation was found to indicate that an interview was conducted with the resident prior to 5/31/24. Surveyor also reviewed that there was no written statement from the Business Office Manager. 4) Review of Resident #44's medical record revealed the resident had a September 2024 BIMS score of 15 out of 15 indicating the resident was cognitively intact. During an interview on 12/10/24 the resident reported staff having yelled at him/her, the resident was unable to provide specifics but stated that it had been reported to the big boss. On 12/12/24 at 12:20 PM surveyor requested from the DON any facility reported investigations involving Resident #44. At 12:40 PM the DON reported that there were no facility reports involving this resident. At 12:43 PM surveyor informed the DON of the resident's report. On 12/19/24 surveyor reviewed the facility investigation documentation regarding this allegation. This review failed to reveal documentation to indicate an interview was conducted, or attempted to be conducted, with the resident by facility staff regarding these allegations. On 12/20/24 at 1:05 PM the DON confirmed that no one interviewed the resident about the allegation of abuse.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 45139 Based on medical record review and staff interview it was determined that the facility failed to ensure the required transfer information was documented in the medical record when a resident was transferred to the hospital. This was evident for 1 (Resident #267) of 4 residents reviewed for hospitalization during the annual survey. The findings include: On 12/13/24 at 8:36 AM review of intake #MD00184369 revealed a concern regarding Resident #267's elopement from the facility and subsequent hospitalization . On 12/13/24 at 10:22 AM review of progress notes revealed a nursing note dated 10/11/2022. Review of this note revealed that Resident # 267 returned to the facility at 07:40 AM from the Hospital emergency room the morning on 10/11/22 at 7:40 AM, in a stable condition, with an abrasion on both bilateral lower extremities. Further review of the progress notes failed to reveal documentation that the resident was transferred to the hospital or the reason for the transfer. Continued review failed to reveal a hospital transfer note indicating what documents were sent with the resident to the hospital or if the Physician and/or the Resident #267's family were notified of the transfer. In addition, the review failed to reveal how the resident was transferred to the hospital. On 12/19/24 the assistance director of nursing (ADON) provided a Document Titled Sterling-Care South Mountain Hospital Transfer Document Checklist. Review of this hospital transfer check list revealed that when a resident is transferred to the hospital the following should be documented in the medical record: hospital transfer note should include reason for transfer, the physician and resident's personal representative notified, and how the resident was transferred to the hospital. On 12/19/24 at 8:08 AM the ADON was interviewed regarding the documentation for Resident's #267 transfer to the hospital. The ADON failed to provide any of the documents listed in the Sterling-Care South Mountain Hospital Transfer Document Checklist, for Resident # 267's transfer to the hospital on 10/10/22. On 12/19/24 at 8:11 AM the above concerns regarding the missing transfer documentation were discussed with Director of Nursing and ADON. No additional information was provided prior to the end of the survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45131 Based on record review, complaint MD00211139 and interviews, it was determined that the facility failed to ensure that residents received the appropriate treatment as ordered, in accordance with professional standards of practice. This is true for 2 (Resident #21 and Resident #110) of 3 residents reviewed during the survey process. The findings include: 1.)On 12/18/24 at 11:37 AM, a review of Resident #110's chart revealed that the resident's Maryland order of Life Sustaining Treatment (MOLST) revealed that the resident was on comfort care and without hospitalization . A review of complaint MD00211139 revealed an allegation that from 10/11/24 to 10/14/24, Resident #110 began experiencing seizures that worsened until death. Further review of the medical record revealed that on 07/10/24 a physician's order was placed: Midazolam HCl (PF) Injection Solution 5 MG/ML (MidazolamHCl) Inject 1 ml intramuscularly as needed for seizure activity; however, there was no documentation to indicate how often the medication could be given or what to do if found to be ineffective. A review of the Medication Administration Record (MAR) revealed that the resident received a dose of midazolam for seizure activity on 10/11/24 at 10:28 AM and that it was ineffective. There was no documentation found to indicate the physician was made aware that this injection of Midazolam was ineffective. There was also no documentation found to indicate staff contacted the physician on 10/11/24 for clarification as to how often the medication could be administered for seizures. Review of the medical record revealed a nursing note dated 10/11/24 at 12:48 PM that stated, episodes of seizures Jerking movements of the arms and legs, Loss of Staring spells or unresponsiveness, [the resident's power of attorney] made aware. Further review of the MAR revealed a second dose of the Midazolam was administered approximately four and a half hours after the first dose, on 10/11/24 at 3:06 PM and was documented as effective. A third dose was documented as administered on 10/12/24 at 8:17 AM and was documented as effective. The 7/10/24 order for the Midazolam as needed for seizure activity was discontinued on 10/12/24 at 12:04 PM. On 10/12/24 1:00 PM, a new order was written; Midazolam HCl (PF) Injection Solution 5 MG/ML (Midazolam HCl) Inject 1 ml intramuscularly three times a day for Seizures 3 Dose Daily. The MAR documentation revealed that the resident received one dose on 10/12/2024 at 5:00 PM. A review of the progress notes and MAR revealed no documentation to indicate effectiveness of the medication administered. On 10/12/202024 at 6:15 PM, an order was updated for Midazolam HCl (PF) Injection Solution 5 MG/ML (MidazolamHCl) Inject 1 ml intramuscularly every 8 hours as needed for seizure, the MAR documentation revealed that the resident received one dose on 10/13/24 at 4:15 am and it was effective. This medication was discontinued on 10/13/2024 11:41am. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/13/2024 at 11:45 AM, an order was updated for Midazolam HCl (PF) Injection Solution 5 MG/ML (Midazolam HCl) Inject 5 mg subcutaneously every 4 hours as needed for seizures, the MAR documentation revealed that the resident received two doses on 10/13/24 at 11:55 AM and 5:23 PM and both were effective. On 12/20/24 at 10:00 AM the surveyor requested the Midazolam drug control sheets from the DON. Review of the midazolam control sheet provided revealed that as of 8/24/24 the resident had two doses of Midazolam available. These two doses were documented as having been removed from the supply on 10/11/24. Only one drug control sheet was provided for review for this resident. There was no documentation provided to indicate where the additional 5 doses that staff documented on the MAR as having administered were obtained. A review of the progress notes revealed that on 10/12/2024 at 12:44 PM pharmacy was called to bring midazolam STAT (immediately). On 12/20/24 at approximately 11:45 AM, the surveyor reviewed the concern with the Director of Nursing (DON) that after the first dose of Midazolam was documented as ineffective, there was a progress note around 12:30 PM indicating seizure activity and responsible party was made aware but no documentation to indicate this information was conveyed to a primary care provider. There was no documentation to indicate how often the midazolam ordered on 7/10/24 could be given or what to do if found to be ineffective. The DON confirmed that she would expect an as needed medication order to include a frequency. Also reviewed the concern that although staff documented multiple administrations after the initial two doses, there was no drug control sheet or other documentation to support that a supply of the Midazolam was delivered for this resident. The surveyor requested any additional documentation to support that the facility had the medication to administer as ordered. The DON stated that she will investigate further and provide any additional documentation; however, there was no additional documentation provided by the time of survey exit on 12/20/24 at 3:00 PM. 2. On 12/18/2024 at approximately 12:30 PM, a review of Resident #21's chart revealed that the resident was being treated for uncontrolled type 2 diabetes. The following physician's order was found: 11/18/2024 Sliding scale insulin: Inject as per sliding scale: if the resident's glucose reading is greater than 350, administer 14 units of insulin and notify the physician. A review of the Medication Administration Record (MAR) revealed that on 11/19/2024 at 11:30 AM, the resident's blood glucose level was 369. However, the MAR revealed that the medication was not administered, and instead the comment #11 indicated held per parameter. Furthermore, a review of the progress notes revealed that there was no documentation to suggest the reason or parameters for withholding the insulin and there was also no documentation to suggest that the healthcare practitioner was notified. On 11/19/2024 at 09:51 AM, during an interview, nurse #46 stated that the insulin administration comment #11 was done in error. She confirmed that no documentation could be found for administration or notification to the healthcare practitioner. The Resident also had an order for: Trulicity 1.5 mg subcutaneously one time a day every Monday related to type 2 diabetes with hyperglycemia. However, a review of the MAR revealed that the resident refused the Trulicity on 12/2/2024, 12/9/2024, and 11/25/2024; however, there was no documentation to suggest that the healthcare practitioner was notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/24 09:51 AM, in an interview with nurse #46, she confirmed that Trulicity was refused on 12/2/2024 and 12/9/2024, and 11/25/2024; however, there was no documentation that the healthcare practitioner was notified that the resident refused for each administration. On 12/20/24 at approximately 11:45 AM, in an interview with the DON, the above-mentioned concerns were presented to the DON and she acknowledged the concerns.